THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. December 1985, Vol. 72, No. 12

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

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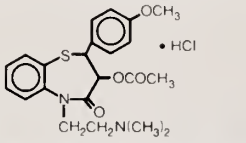
DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

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This month's cover of *The Journal* is a drawing by Jacksonville artist James B. Upright. The cover illustrates the Holiday Season.

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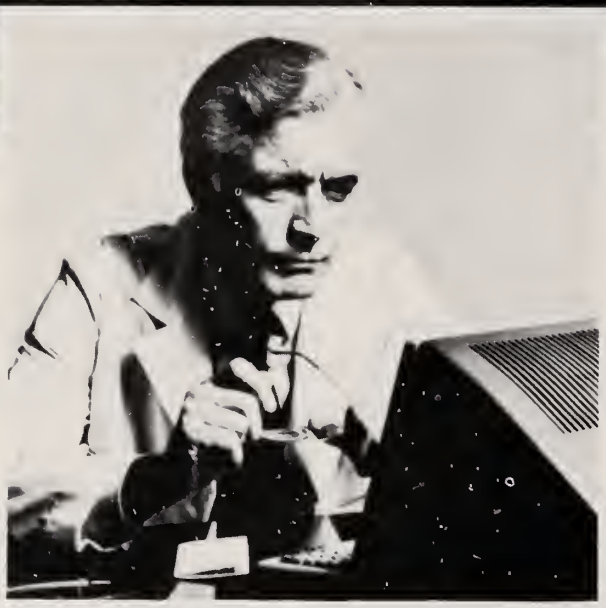

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Richard S. Panush, M.D., Professor of Medicine, University of Florida, College of Medicine, Gainesville, Florida

Oscar D. Ratnoff, M.D., Professor of Medicine, Case Western Reserve University, Cleveland, Ohio

Thomas Spira, M.D., Center for Disease Control, Atlanta, Georgia

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PRESIDENT'S PAGE

Reflections on the past bring goals for the future

At this time of the year, when we celebrate the holidays with our family and friends in a gay and happy mood, all of us should take time to seriously reflect on this past year and make some well thought out plans for the up and coming year.

This year, for the first time in ten years, we saw a crack in the malpractice problem. We have to coordinate our movements and ideas to enlarge that small opening and obtain significant changes next April and May. That, we hope, will ameliorate the crisis in which we have been living with for so long.

We have to make some New Year resolutions and strive to keep these resolutions, such as becoming more interested in the political players of our state and learn how the game is played, so that we will be a more effective contributor in our struggle. We have to make a resolution to actively participate in our endeavors for the good of all physicians and for the benefit of our patients, the citizens of Florida, whose health and well-being are our responsibility.

We have to realize that the only harvest we can sow is from those seeds we have planted earlier, and the more we plant and care for, the better the harvest will be! This requires work and sacrifice from all who want to obtain bountiful results, because this is the only way to obtain results: sweat, toil and perseverance.

We have to use every opportunity, making opportunities if necessary, to talk with our representatives and senators now, when they are at home planning their next campaign. If they are of our liking, and willing to help us in our quest, we must help them in theirs. We must frequently remind them that the liability crisis is beyond the doctors/lawyer's position but a problem of society. They know it; the majority of them are business people or professionals other than lawyers, and even the lawyers are seeing their liability premiums escalate to high levels. We only have to make them aware of what is happening and that the people of the state indirectly are paying for it when these escalated premiums are passed on to them through increased prices for any service.

We have other serious problems approaching us, including the sunset of all the practice acts related to health, and we have to monitor the movements of allied health practitioners that encroach on our profession and obtain privileges for which they are not entitled by their degrees.

At the national level we have to face the attacks from the federal government to curtail medical services to the people. The HMO concepts and their variations open the door for entrepreneurs and corporations to try to control the physicians in this country while making a mockery of the best medical system in the world. All this is at the expense of the people without improving the services of the poor and destitute members of our society. We have to fight in Washington through the channels of the AMA and political work with our members of Congress, senators and representatives.

While reflecting, we must realize the strength that the medical community can have if everyone of us sacrifices some leisure time and works towards a

common goal. No organization can control physicians, unless the physicians themselves agree to be controlled and managed.

While thinking of the future, let us remember the past; we were able to practice medicine freely and efficiently without curtailment from any quorum or the pressures of malpractice. That is the medicine young doctors do not realize, those were the days when we really enjoyed practicing our profession. We owe to the young doctors of today, and the ones that will follow, such an environment. We have to find the formula to obtain that for the people of the state, preserving the quality of medical care and the opportunity like the past.

This coming year, let all of us resolve that we will pursue whatever sacrifice necessary to give a powerful push to our goals and make the whole nation realize that physicians of Florida, united in a common goal, can produce changes never before achieved.

EDITORIALS

The message of Christmas

"There's a beauty when it's Christmas
All the world is different then
There's no place for petty hatred
In the hearts and minds of men."

Christmas is our greatest holy day. Dedicated to children, laughter, love and sympathy, good impulses and the well-being of us all, Christmas is a tradition shared by all faiths. On this day in Bethelehem, with the birth of a child was born the concept of loving one's neighbor and of peace among nations. This was the child who grew to be the greatest believer in the human rights of man, a defender of women and children, one whose heart was always with the sorrowful, one who became great as measured not by the number of people in the world who feared him but by the number of people he freed from fear. Founding all progressive thought, He stressed the importance of compassion and integrity in a world full of neither.

Yet in the touching trust of childhood which can always be deceived, though never discouraged, lies the hope of the future of the world. To bolster this hope, we need only to follow the teachings of Him, the Prince of Peace whose message was that the mighty shall be toppled when their ways are wicked, for man's end is not power but peace and justice, and peace is impossible and justice a mockery unless power is put where it belongs in the hands of men who cherish wisdom and righteousness.

In spite of corroding cynicism, pessimism, greed, love of luxury and crass materialism, an individual's genuine needs are self-confidence, self-esteem, and self-sacrifice; and these can only be achieved by giving not getting, for to love people, to be indispensable somewhere, this is the purpose of life. By weaving a tiny personal thread of morality in our own lives, so can a nation weave a rope of exact and universal justice for all. The idea of morality goes to the bottom of men's relation with one another in terms of brotherliness, tolerance, help and mercy for there is always a universal hunger in the hearts of men for love, justice and truth.

The message of Christmas, "Peace on Earth" is a daily prayer in the hearts of enough Christians to drown the hue and cry of the hucksters, that the light of wisdom that blazed in the sky as a star shining on that first Christmas night, will someday enlighten the entire civilized world. Though this hope of peace on earth shining almost 2000 years ago still seems like a distal goal, yet each year at Christmas, hope is renewed to keep the faith that someday lasting peace and brotherhood will finally be achieved throughout the world. Christianity is an intensely practical religion not designed to change the way we think or believe as much as to change the way we act, yet what cannot be followed in day-to-day practice cannot be called religion. While many wrangle for religion, write for it, fight for or even die for it, Christmas teaches us to live for it.

Regardless of religious affiliation, we should resolve that on this day we will rededicate ourselves to those purposes which keep freedom alive, because without freedom there can be no justice and without justice there can be no peace on earth.

As it is impossible to have a good opinion of one's self and a low opinion of others, Christmas means you cannot love God without loving every fellow creature He made, and an act of contempt or rejection or neglect toward the least, the lowest, the poorest, or the weakest is an act against Him.

The meaning of the miracle behind the Christmas story is the simple miracle of understanding love, for the power to love was the Christ child's gift to all mankind and it can never be taken away from those who love. As it is in serving we are served, so it is in loving that we are loved.

And blessed are those who see Christmas through the eyes of a child. This is man's greatest gift at Christmas.

Clyde M. Collins, M.D.
Contributing Editor
Jacksonville

Cigarette smoking on trial

A strange but potentially landmark-setting courtroom drama pitting certain lung cancer victims against the powerful tobacco industry will be unfolding in the next several months. The lawyers representing the plaintiffs, who have all been chronic heavy smokers, are expected to contend that the cigarette manufacturers have withheld vital information concerning the dangers of cigarette smoking and have thus been remiss in failing to warn the public more adequately than current cigarette labeling does. Nonsense, the other side will argue; people who smoke know what they are doing, are aware of the hazards to their health of smoking, and should blame nobody but themselves if they get sick.

Very few people give the cancer-stricken patients any chance of winning the case; if they win, however, it would deal cigarette smoking a mortal blow that no previous effort by mankind had been able to deliver. It would indeed be a supreme irony to think that this may happen, but I hope it does not.

My sympathies lie with the cancer victims, some of whom may not live long enough to hear the verdict, but I am not swayed by their argument that they were victimized because they were not given enough warning about the hazards of smoking. I prefer to think they were victims of their own dangerous lifestyle, or addiction, or whatever you want to call it. The warning about smoking being hazardous to one's health is explicit and is found in every cigarette case; furthermore, it is common public knowledge that smoking causes a variety of illnesses, including cancer of the lungs, even though the cigarette companies are reluctant to admit this. But nobody is compelled to buy cigarettes and smoke them, much in the same manner that nobody is compelled to gorge one's self to obesity and die of premature atherosclerotic heart disease, or to sniff cocaine and blow up one's mind in the process. Much as a lot of us distrust tobacco companies, I happen to agree with them that the central issue in this case is individual responsibility. People who do certain things knowing that they may be risky should not be pointing fingers at other people if something goes wrong. To permit that would be to destroy the fabric of our society and to replace order with mayhem.

But what if the court decides that the cigarette manufacturers are indeed culpable of neglecting to give adequate warning to the public about the hazards of smoking? I can just imagine the resulting fall-out. McDonald's, Wendy's and Burger King will most likely be asked to warn their customers that eating their hamburgers will result in obesity, high cholesterol, heart disease, and strokes. The National Rifle Association probably will be ordered to modify its slogan to say that people do not kill people; guns do. Liquor manufacturers will be required to state on their labels that alcohol may cause cirrhosis of the liver, malnutrition, intoxication, or some other form of anti-social behavior. The possibilities are endless, but then the fun of living and doing a few dangerous things will be gone. The stability of our society would appear to be better served if the court finds that the suit against the cigarette companies is frivolous, which in some respects it is.

A better way to fight the cigarette manufacturers without abdicating our personal responsibilities or vicariously transferring these responsibilities to others when we should not is by confronting them with the mounting mass of evidence that we have against smoking, educating the public, and persuading the government to regulate the manufacture of tobacco and perhaps ban it altogether. Judging, however, from our previous record of failing to prohibit the use of alcohol, any similar attempt to ban the use of tobacco probably will be impossible. My hunch is that despite the scientific evidence, the government will continue to permit the use of tobacco with little or no modification of the warning that the Surgeon General now requires tobacco companies to place on their packages. Those who want to smoke and enjoy it should do so; if they stay healthy, more power to them. If they get sick, that is their tough luck. But please, let us not pass the buck to somebody else.

Whether the suit produces a landmark decision or not, it has stirred an unusual amount of interest from all sectors of society. The financial repercussions boggle the mind if some wise judge or jury finds that the tobacco companies are guilty and should compensate the current plaintiffs and all past and future victims of cigarette smoking. Such is not likely to happen. Physicians who have been crusading against the evils of smoking will be happy with a decision that will require more strict labeling on cigarettes. That would be at best a Pyrrhic victory. Do we honestly think that people will quit smoking by changing the labels on cigarettes? I doubt it, but I hope I am wrong.

R.G. Lacsamana, M.D.
Editor

Corporate medicine and the American spirit

As a former social historian, I have often looked at the elusive American spirit or character, that multifaceted entity which has been difficult to define, but which exists nonetheless. Throughout the history of this nation, all observers of American society have agreed that there are definite qualities which combine to make Americans unique. These qualities have been molded by the American experience, from the discovery of America to the migration westward and the development of an industrial world power.

Perhaps the foundation of our uniqueness is centered in our forefathers who represented the pioneer spirit and underwent great hardships and yet persevered and endured with a spirit that only can be described as irrepressible. America is a nation of immigrants, and whether these immigrants came from Ireland to escape the potato famine of the 1840's or from Europe to escape the oppression of Nazism during the 1930's, all of them were amalgamated into "Americans" and helped to give us the American character. This character was honed by hardships, such as the Civil War, the great Depression of the 1930's and two World Wars. It was strengthened by hardships on the Oregon Trail during the 1840's and droughts in Kansas in the 1880's.

The result of the building of this American character was apparent in the early days of our nation when our qualities set us apart as early as 1770 and helped lead to the American Revolution as England never really understood what made up the American character. This misunderstanding was partly responsible for our fight for independence. By the late 1800's the typical American was vastly different from his European cousin. While the ideas o socialism swept Europe, Americans had no time tc toy with this idea. We were too busy expanding westward, building our industrial plants and establishing our own identity. Besides, we were imbued with the spirit of capitalism.

What is the American character? It is many things. Above all, it is individualism, pragmatism and a toughness which may be disguised, but is always present. As a nation, we are the best fed, best housed and with the exception of the Civil War, have never had a major war on our soil. Because of our standards of living many nations have underestimated the American character as being one of softness — and have paid for that mistake as did the Japanese warlords in World War II. The American toughness and ability to suffer great hardships is illustrated in the Civil War when Americans fought some of the most sanguinous battles in history and troops from both sides, Americans all, continued to answer the bugle call for more charges and self-sacrifice.

With this toughness, and perhaps out of the pragmatic nature of the Americans, would come the desire for experimentation and innovative thinking. This would apply to all phases of society and particularly to the economic sphere when we built up the capitalistic system to the most efficient in the world. It has become as American as apple pie to do things the capitalistic way. Let the market place decide. The hard worker and the intelligent investor will be the winner. The thinking behind this is that the public will choose the best product, at the best price and economic competition is the backbone of our society. Indeed it is and it should be.

Today, the rise of corporate medicine has generally been received with either scorn, fear, or great expectations that this movement is the ultimate of the capitalistic system. Regardless of one's own personal feelings, there is little doubt that corporate medicine has become the newest player in the game and may be the principal player in the next decade. Those who expect corporate medicine to dominate the medical scene and private practice, more specifically fee for service, to decline to negligible levels have based their observations on several things. For one, they point to various aspects of American society which have supported the concept of market place competition and now are ready for corporate medicine. The supporters of this viewpoint feel that Americans will support this movement because it promises economic competition, lower prices and restraint of runaway health costs. They feel that our capitalistic heritage makes this concept viable and acceptable to Americans.

They are both right and wrong. They are right that the American people are ready for a change in the health care of this country. They are frightened by the rising costs and the seeming inability of the medical profession to hold costs down. They are wrong to think that the American people will accept corporate medicine in the manner it is being delivered or to allow the medical system to be permanently "incorporated."

From a social historian's point of view, I see a different scenario. The American people have been in favor of the corporate direction of medicine to this point. We tend to try to change things when we perceive that they are not working. From one viewpoint, the medical system was not working and something else should be tried. However, those who point to these reasons for the continued success of corporate medicine have failed to look at the other facets of the American character. Throughout our history we have experimented with many aspects of our society, but above all have maintained a firm belief in individuality, fairness and a desire to address perceived wrongs.

It is my feeling that corporate medicine will not be what the American people seek in the final analysis. True, it may cut costs, but at what price? Surely, all observers would agree that individualism has been subordinated to other factors. While the American people want to have economical medical care, I do not think they will accept a loss of their individual choices as an acceptable exchange. Americans will not accept a system that sets economics above all else. I know there are no studies to show that corporate medicine has led to decreased medical care, but I think there is no doubt that the level of medical care of this country will certainly not be the same in the future under corporate medicine. Americans also will not allow a system that leaves out the poor. It appears that corporate medicine has the potential to foster a two-tier system. One tier consists of those who are able to pay or have insurance and another tier consists of the medical indigent. Traditionally, the poor of this country have been taken care of by hospitals and physicians who by legal and moral reasons accepted this as part of the practice of medicine. The rise of corporate medicine threatens to leave the poor out of the medical system as profits are the bottom line and providing medical care without compensation is not "good business."

No, I think corporate medicine as we see it will not survive. I also think that medicine will never go back to what we knew prior to corporate medicine. What will evolve will be some of the elements which corporate medicine offers, such as cost restraints and strict utilization reveiw. Other factors which Americans cherish, such as freedom to choose individual physicians or methods of treatment, belief in fee for service — with some modification and controls — and available medical care for all Americans, regardless of ability to pay, will also reappear. The trend to corporate medicine and its eventual modification to a more traditional concept is in keeping with the American character to try to fix things that we perceive are not working and then to modify what has evolved. This change from corporate medicine will not come quickly and will probably take at least two decades before we work through this concept.

The American spirit simply will not let corporate medicine be the end result of the evolution of our system of medical care.

H. Frank Farmer, Ph.D. M.D.,
Historical Editor
New Smyrna Beach

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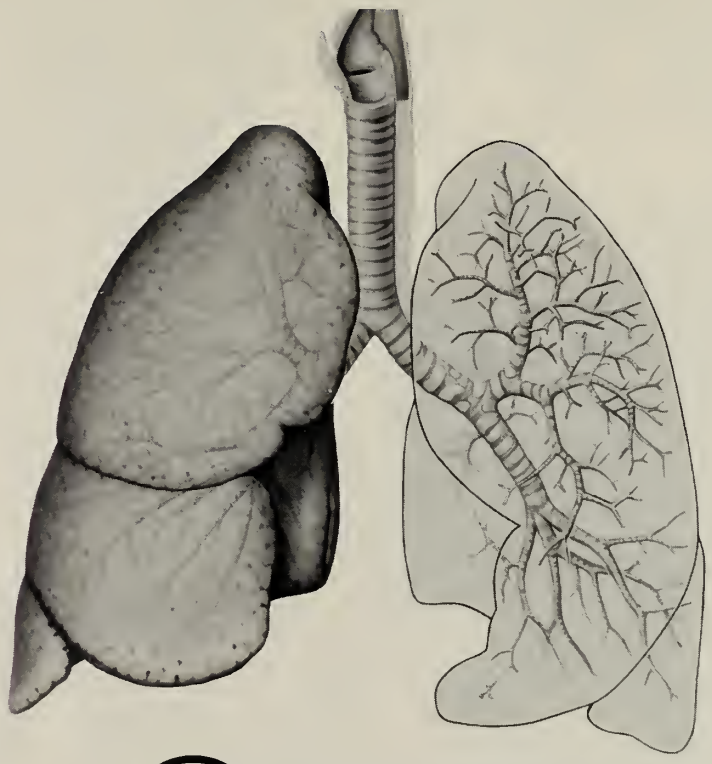

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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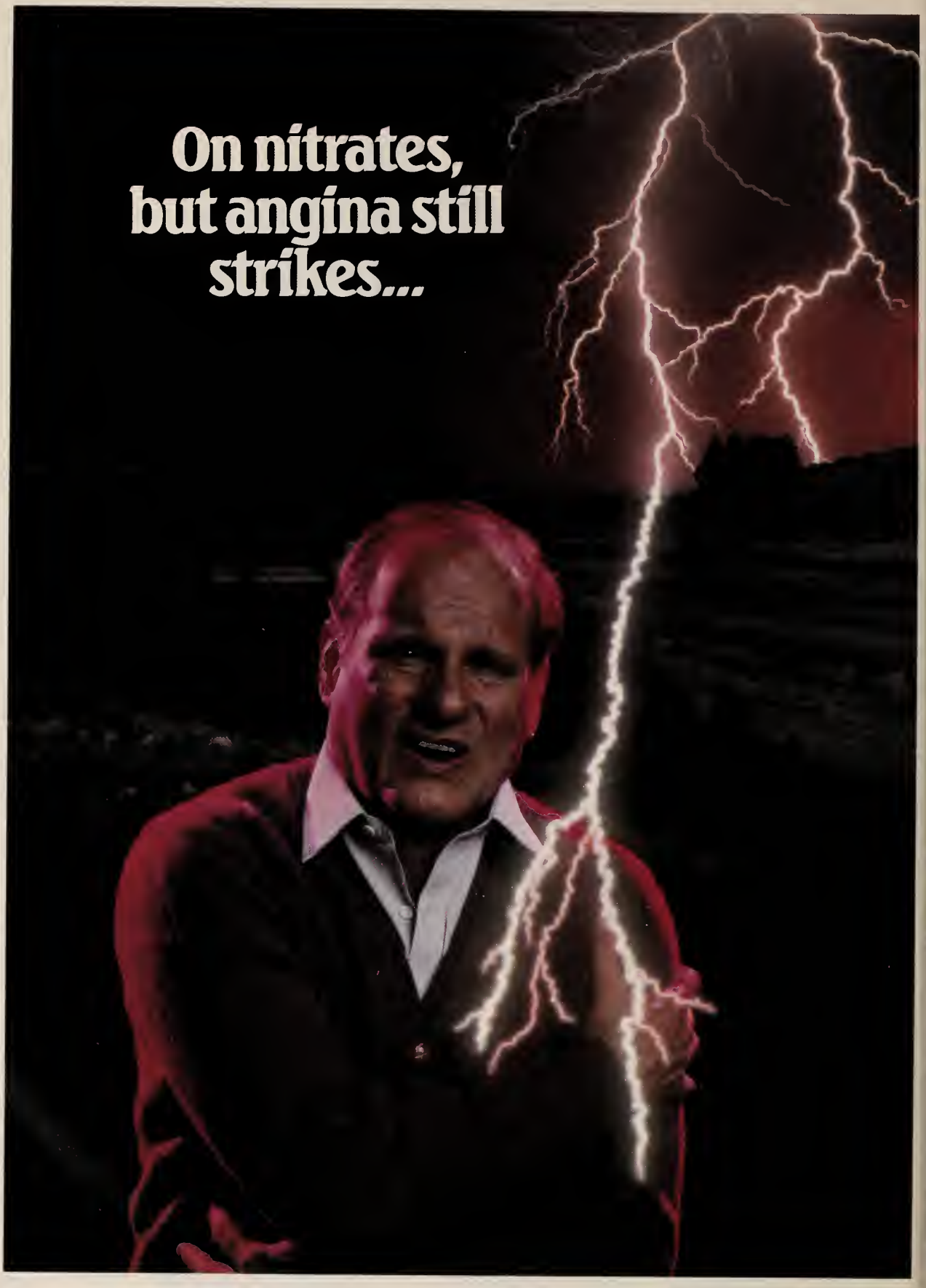
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Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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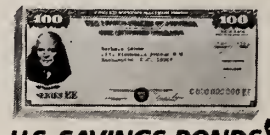

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Should pharmacists be allowed to dispense and prescribe?

Pharmacists are members of an esteemed and ancient profession who, in Florida as elsewhere, are educated and licensed to prepare and dispense medications for the treatment of human disease. In the not too distant past, pharmacists spent much of their time compounding medications for patients, but at present most medications are prepared by pharmaceutical manufacturers, leaving pharmacists to count, dilute, dispense, and label drugs according the physician's directions on the prescription.

A properly educated and competent pharmacist must fill prescriptions correctly, detect ones that are improperly written, substitute less expensive generic equivalents of brand name drugs, and advise physicians when a patient is taking drugs which may be incompatible with a new one prescribed.

Pharmacists may also offer advice to patients who are looking for a nonprescription drug to treat a particular disorder or symptom. Most people attempt to treat themselves for whatever medical condition may arise, for at least a week or two before deciding to seek the attention of a physician; such procrastination is only partially related to the cost of visiting a physician. Most people want to maintain control over their own bodies and spare themselves the anxiety that is often created by visiting a physician and possibly leraning bad news. Health surveys bear out that people wait for varying periods of time, even for an illness that they fear may be quite serious before making the decision to visit a medical doctor.

It was with both shock and dismay that I read that the Florida Legislature, the only state legislature in the nation to do so, granted pharmacists in this state permission to act like physicians: to examine patients, make diagnoses, and prescribe certain federally legended drugs: i.e., those that ordinarily require a physician's prescription. While physicians are educated and licensed to diagnose, operate, prescribe and dispense, it must be emphasized again that it is not within the education or training of pharmacists to examine patients, and to make diagnoses and prescribe.

As a dermatologist, whose specialty is being encroached upon by an ever enlarging variety of health care practitioners who believe they can treat skin disorders as well as someone who has completed a three year residency in that specialty, I am particularly offended by the Legislature's specific interest in making certain dermatologic medications, like lindane, available for use by pharmacists.

When I heard of the legislation, Chapter 85-35, written by House member and pharmacist Everett Kelly, (D-Tavares), a fantasy scenario immediately filled my imagination. It begins when a very itchy patient enters a chain store pharmacy in Miami or some other large city. He has been itching for three weeks, and has already tried four or five over-the-counter preparations without relief. He had worked himself up to the mind-set required to visit a physician, perhaps even a dermatologist, but a co-worker suggests that he make a professional visit to the pharmacist at the chain store near the supermarket. This patient, and in fact his co-worker, do not have any particular pharmacist in mind, but believe the young fellow with the little beard on the 3 p.m. to 11 p.m. shift might be pretty good.

Several possible scenarios emerged from my imagination at this point: in one, the pharmacist, a nice young man in his thirties, looks down from the pharmacy counter to the fully clothed itchy man and decides that he has scabies and orders lindane, a medication that he has been authorized to use by the Legislature. In a second possible scenario, the pharmacist steps down from behind the counter, and in

the busy and poorly lighted pharmacy aisle, among the parade of other customers and between the toothpaste and the laxative shelves, begins to examine the client, asking him in that public place to remove various items of clothing in order to fascilitate his inspection.

Along with this authority to examine patients and prescribe medications, the Legislature went along with Mr. Kelly's desire to allow pharmacists to bill third parties, not only for the medication, but for making the diagnosis as well. Mr. Kelly professed that his legislation was intended to "save Joe Lunchbucket or Jane Q. Public the $30.00 charged by the average physician for an office visit," but his legislation will not save us all from charges made to third parties by pharmacists who are trying to play doctor, although they lack the expertise and credentials to do so.

In a typical legislative ploy to cover themselves while they transgress into the domain of a properly educated and licensed profession, the Florida Legislature created a joint committee, which is authorized to determine which other prescription drugs pharmacists are entitled to use, in addition to those already spelled out in the legislation: lindane, flouride, antihistamines and decongestants. Naturally, three of the six joint committee members are pharmacy board members, stacking power on the side of those who would perhaps make all pharmacists into physicians.

Misery certainly loves company, and in our wonderfully litigious society, I expect and perhaps even secretly hope that certain agressive pharmacists and perhaps even the Legislature will get their just dessert for having foolishly, and perhaps even maliciously, given legal authority to one profession to perform the services of another.

The personal injury implications of this legislation created another scenario, in which the patient is again standing in a dimly lighted pharmacy, and from a distance of about 8 feet the pharmacist determines that the poor man has scabies and needs lindane. My fantasy, (or nightmare, according to your point of view), continues with the patient going home and either ingesting the lindane, and suffering a serious and perhaps even fatal case of chemical hepatitis, or applying it properly but developing an anaphylactic reaction and dying. It would be shown at autopsy, the dream continues, that he never actually even had scabies, but some other dermatitis. In addition, he had once before demonstrated an allergic reaction to lindane, which gone undetected by the pharmacist. The scenario concludes when the grieving young widow and her eight preschool age children sue the pharmacist, the drug store chain, and perhaps even the Legislature for their actions which culminated in the young man's premature demise.

In reality, I do not imagine any significant impact on the practice of either medicine or pharmacy from this particular legislation. The few drugs authorized in the law are generally safe and I believe that the joint committee will become mired down in partisan issues, and will accomplish very little. Most pharmacists are content with their own profession, and have no desire to practice medicine, a profession with greater celebrity status, but one whose members are plagued with significantly more anxiety and despair.

The serious consequences of this legislation concern the audacity of our Legislature to grant individuals power for which they lack the education and training, and its passage establishes a precedent for the wanton disregard of traditional values by our state leaders, while producing very little, if any benefit to anyone. A rational way to have solved this problem could have involved the creation of a joint committee to find those prescription drugs which could be made nonprescription, so that pharmacists could counsel store customers on their usage, rather than authorizing pharmacists to behave like physicians, which they are not.

Richard J. Feinstein, M.D.
Contributing Editor
Miami

Save us from the doctors?

The editorial reprint, "What kind of justice is this? Save us from the lawyers" would have been better captioned "Save us from the doctors and corporations." It is indeed strange when the writer of the editorial mentions several rather horrendous medical results certainly not caused by lawyers and yet concludes that it is the lawyers from which we need to be saved. His bias is certainly showing when he admits that filing for bankruptcy by Robbins in the Dalkon Shield cases is a dirty trick, but then proceeds to say, "Who can blame them?" Certainly he is charitable towards the wrongdoer. His bias is certainly evident when he then proceeds to castigate the only profession that stands up for the helpless victim in an otherwise hopeless struggle against the physicians and giant corporations: the lawyers.

What would happen if there were no lawyers to represent injured patients? This article contains the answer. There were 49 deaths in the Oraflex cases. The government fined the company a total of $25,000. Let the people choose which system they would prefer.

The author there commits a common error. He somehow equates a demand for a damage amount ("suing for") with an actual recovery. Rarely is a

recovery ever close to the demand made in the complaint. Just because there is a claim filed does not mean that there will be that kind of recovery. Even if there is a large verdict by a jury, that does not mean it will ever be collected. Consider the celebrated $14 million verdict obtained in Broward County for a totally helpless victim. That verdict was overturned on appeal. All the publicity that went with the verdict has made its impression. Not many people know that the victim has received not one penny of that money, nor has the lawyer. The case will have to be retired.

I think it is significant that Mr. Knight (the writer of the editorial) ends his article with the impotent and totally unhelpful suggestions "there must be a better way." If there is a better way, let him suggest it. In most cases, the "better way" has ended up being the worse way. The simple tort system with trial by a jury is the best tool of justice the world has devised. Far from perfect, but also far better than being at the mercy and caprice of an all powerful government with its hopeless bureacratic morass.

The medical profession may soon have to decide whether it wants to pay for its mistakes in the tort system or surrender to government control. When the government pays your bill, then the government also will pay for the mistakes. However, your cherished freedom disappears at the same time. This is probably the decision the medical profession is facing now. With government protection comes government control. That control means control of practice as well as income. Take your choice.

Walter C. Ward, M.D., J.D.
Miami

Editor's reply: Dr. Ward apparently missed the entire point of the editorial. Mr. Jerry Knight, who wrote the editorial originally for the *Washington Post*, was decrying the current tort system and all the evils that it has bred in American society. It is a system that invites people to sue at the drop of a hat, making adversaries of us all, costing billions of dollars, and dispensing justice neither to the plaintiffs nor to those who are sued. The lawyers, as everybody knows, are the only winners. There is only a vestige of justice when even those who need to be recompensed for their injuries end up with outrageous and unconscionable awards, with the lawyers of course sharing in the booty.

Mr. Knight was so right in stating that ". . .lawyers are largely responsible for the entire nation's befuddled view of how victims of wrongs should be compensated." No other nation in the civilized Western world dispenses justice with the kind of brutal tort system that we have here.

Dr. Ward perceives that physicians will now have to choose between paying for their "mistakes" in the tort system and surrendering control of their profession to the government. That is an arrogant and self-serving view of the problem. Dr. Ward surely must now be aware that the evils of the current tort system have about pervaded every segment of American society, making liability protection extremely expensive and sometimes unavailable. If the government intervenes by way of federal legislation to curb the abuses of the system, as it is planning on doing, it will no doubt be good for the public, but bad for the lawyers.

Is there a better way than the lawyer-to-lawyer combat we now see with our current tort system? Certainly. Many sensible suggestions have been made through the years, including one repeatedly made by Chief Justice Warren Burger but consistently ignored by the lawyers, and that is the use of more arbitration. That, of course, would drive many lawyers out of business.

A new life after by-pass surgery

I am reminded of a patient's remarks after we Americans landed on the moon. She said, "They better leave God's moon alone."

This attitude could be just as appropriate for tinkering with the human heart, which everybody knows is the sine qua non of life itself. I must confess that a number of us are influenced by superstition. As someone who has had to learn anatomy and physiology of the most remarkable organ of our body, I have always felt too much awe for it to be handled with anything except the most careful respect. It most nearly approaches perpetual motion than any other portion of our machinery. When all other organs are allowed periods of rest, it must function day and night, awake or asleep, active or inactive, conscious or unconscious. At seventy-seven years of age, I often pat my chest and say to my heart, "Old boy, you have done and are doing a wonderful job." My gratitude to nitroglycerin and by-pass surgery may yet cause it to swell and burst.

For ten years before July, 1984, I was having episodes of angina and had progressed to the stage of having to take a nitroglycerin tablet after walking a half block or after any mild emotional stimulus. That little pill, by the way, was more valuable to me than all the diamonds in Africa.

When catheterization showed significant obstruction in three of my major coronary vessels and partial occlusion of my left femoral artery, I had a triple by-pass operation in July of 1984 and femoral dilation. My awe of the heart and its function did not give me a moment's hesitation in opting for the

surgery. I took this as an excuse to retire from active practice. The operation was an outstanding and remarkable success.

This last year and a half has been the most enjoyable time of my life. Do not let anybody tell you that a workaholic physician with fifty years of service under his belt cannot enjoy retirement.

I am not taking medication of any kind. I have discovered the joys of the privacy, liberty and relaxation of my home. I can relish more opportunities for the companionship and friendship of my wife, children and former patients. I have been active in more civic affairs and in church work. With the present need for volunteer services to help our country's need for cost containment, I can have just as much work as I want. I have been able to indulge in cultural activities which have previously been only objects of envy to me and beyond my grasp. They include art, literature, music and travel. Recreation including fishing and golf contribute even more to my joy of living. Who could ask for anything more?

H. L. Harrell Sr., M.D.
Ocala

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Screening for diabetes mellitus

Arlan L. Rosenbloom, M.D., John I. Malone, M.D., Anthony D. Morrison, M.D., and Jay S. Skyler, M.D.

ABSTRACT: Testing blood specimens for glucose level has long been a highly visible activity of voluntary groups. Such casual testing, however, lacks specificity as well as sensitivity and is difficult to consider as a public service. Even if it was reliable and follow-up assured, there is no evidence that early detection of asymptomatic diabetes is associated with improved outcomes. Recommendations of the 1978 Atlanta Workshop on Screening remain valid: general population testing is not recommended, case-finding in pregnancy should be routine, screening for diabetes should only be part of a well-designed focus on high-risk populations or research questions, and monitoring of known patients for complications of diabetes should be done.

The Authors
ARLAN L. ROSENBLOOM, M.D.
JOHN I. MALONE, M.D.
ANTHONY D. MORRISON, M.D.
JAY S. SKYLER, M.D.
Dr. Rosenbloom is Professor of Pediatrics and Director of the Diabetes Research, Education and Treatment Center at the University of Florida College of Medicine, Gainesville; Dr. Malone is Professor of Pedicatrics and Codirector of the Diabetes Center at the University of South Florida College of Medicine, Tampa; Dr. Morrison is Associate Professor of Medicine, Codirector of the Diabetes Center at the University of South Florida College of Medicine, Tampa; and Dr. Skyler is Professor of Medicine and Pediatrics and Director of the Diabetes Center at the University of Miami School of Medicine.

The inherent value of screening the population for hyperglycemia has long been an article of faith and a cornerstone of voluntary health agency activity. However, in 1974 the American Diabetes Association stopped advising routine screening of school children as a chapter activity,[1] and the Atlanta Workshop of 1978 recommended that only highly circumspect screening for the adult population be applied.[2] Nonetheless, people active in lay and professional associations continue to promote and support screening in the hope that it is of value to the community. Is there any evidence that screening is of value for communities? In order to answer this question we need to review the natural history of diabetes, the qualities of screening, and the evidence that intervention at an early stage affects morbidity and mortality in diabetes.

Natural history of diabetes mellitus • In 1979 the National Diabetes Data Group (NDDG) adopted a classification of diabetes and other categories of glucose intolerance which has proved useful for communications among investigators and for standardization of epidemiologic data.[3] The conditions defined in this classification include: insulin-dependent diabetes mellitus (IDDM), noninsulin-dependent diabetes mellitus (NIDDM), other types of diabetes due to pancreatic disease, hormonal abnomalities, drug toxicity, etc. (secondary diabetes), impaired glucose tolerance (IGT), and gestational diabetes and impaired glucose tolerance in pregnancy. This classification has certain theoretical and practical problems because it is based partially on etiology and partially on degree of impairment. The classification was devised to reduce confusion but substantial numbers of patients continue to fall

between categories. In spite of these shortcomings the adoption of this classification has markedly improved scientific communication. The criteria for diabetes were based on bimodality of responses to a standard glucose load in a population with a high prevalence of NIDDM (Pima Indians);[4] the appropriateness of these criteria has recently been confirmed in a different population.[5]

The stages in the natural history of diabetes apply regardless of etiology. First is the stage of susceptibility which could be based on either genetic risk (e.g., HLA-identicality with an IDDM sibling or monozygotic twin of a NIDDM patient) or falling into a high-risk population due to race, obesity, or pregnancy history (large babies). The next phase is glucose intolerance which we now recognize to be a phase of IDDM as well as NIDDM. Between susceptibility and glucose intolerance, reduction in early phase insulin release to IV glucose can be demonstrated in IDDM. Not all those with IGT progress to symptomatic diabetes. The third phase of the natural history is diabetes mellitus without complications; the fourth phase diabetes with complications but without disability due to them. The last phase is diabetes with disability due to functional impairment from the complications including end-stage renal disease, blindness, neuropathy, cerebral vascular disease, peripheral vascular disease or cardiac disease. The theoretical basis of screening is that detection at the stage of impaired glucose tolerance or early diabetes without symptoms can lead to intervention that will prevent or forestall progression to the more morbid stages. Before this issue is considered, we need to look at the characteristics of screening.

Characteristics of screening • Much of the controversy surrounding screening in general and diabetes screening in particular comes from confusion about the definition of screening and its goals. Three activities that resemble screening need to be defined: epidemiologic survey, casefinding, and diagnostic testing.[6]

Screening involves the testing of apparently unaffected volunteers in order to categorize them into those that are likely or unlikely to have the condition in question. There is an implicit promise of health benefit to the volunteer who has been screened.

The epidemilogic survey measures demographic, social, behavioral, and biologic characteristics of representative samples of carefully selected populations. These measurements may be unrelated to specific disease entities and their objective is that of acquiring new knowledge. Although health benefit may derive indirectly from an epidemiologic survey, no specific health benefit is implied.

Casefinding is often confused with screening. Casefinding is the testing of patients who have sought medical service for other reasons. Although the testing of all pregnant women for diabetes is frequently referred to as screening, it is really casefinding. This distinction is important because casefinding is part of comprehensive, community-standard practice. It is directed to a high-risk population and reflects the judgment of the attending physician that a certain group of patients should be routinely examined in a specific way. This is quite distinct from a screening program where the volition is that of the volunteer.

Finally, diagnostic testing is the application of various questions, examinations, and tests to patients in order to identify the exact cause of their chief complaints. Although a participant in a survey, volunteer in a screening program or recipient of casefinding may be seeking diagnosis, the purpose of their testing is not specifically diagnostic. If there are positive results for the study in question, diagnostic testing would then be appropriate.

Requirements of a screening program • The first requirements for a screening program is that there be a relevant test available which is predictive. Random blood glucose determinations are difficult to interpret in a screening program because the glucose level is affected by time of day, duration of fasting, concomitant illness or stress, as well as glucose tolerance. The NDDG criteria are based on fasting and postglucose loading levels over a 2-hour period.[3] If screening was confined to fasting blood glucose levels, diagnosing diabetes when the fasting level is over 140 mg/dl, consistent with NDDG and WHO criteria, only 13% of those diagnosed as having diabetes by a full 2-hour GTT would be detected.[7]

Another requirement of a screening program is that the condition be perceived as serious by the target group. In most populations, this is true of diabetes in a general sense, but how seriously individuals regard "a touch of diabetes," i.e., asymptomatic disease that has been detected by screening and subsequent diagnostic testing, remains to be established.

High prevalence is another condition for a successful screening program. The low prevalence of IDDM and its explosive clinical onset (despite long latency demonstrable by impaired glucose tolerance and islet cell autoimmunity) were principal reasons for abolishing screening of school children. The prevalence of diabetes increases with age and is higher in females and Blacks in the U.S. It is estimated that 8.5 million persons have diabetes in the age group 20 to 74 years, based on the recent Second National Health and Nutrition Examination Survey (NHANES II).[7] However, as noted in the NHANES II study,[7] detecting the asymptomatic group that accounts for approximately half the

Table 1. — Methods in Screening For Diabetes.[14]

	SENSITIVITY	SPECIFICITY	COST
Urine			
Fasting	Very Poor	Fair	Inexpensive
Postprandial	Fair	Mediocre	Inexpensive
Casual	Poor	Fair	Inexpensive
Blood/Plasma			
Fasting	Fair	Good	Intermediate
Postprandial	Good	Good	Intermediate
Measured Load (Cola, Glucose)	Very Good	Very Good	More Costly
Casual	Fair	Fair	Intermediate

estimated diabetic population in the U.S. requires measures beyond screening.

A fourth requirement for a screening program is that community resources be available for follow-up of the individuals tested positive. It is unusual for a voluntary screening program to assure such follow-up, but it is not ethically proper to carry out a screening program in the absence of such a system.

The most difficult requirement of a screening program is that treatment be available for the condition identified which is more effective when given in the presymptomatic period than in the clinically symptomatic period. Looking first at impaired glucose tolerance, it is estimated from the NHANES II survey that 4.7% or 7 million Americans aged 20 to 74 years have IGT.[7] Data from England suggest that approximately 1/5 of them will develop diabetes over the subsequent decade.[8,9] However, over half will actually experience improvement in their impaired glucose tolerance. In some studies, the degree of obesity may be related to the rate of decompensation[10,11] but there is no evidence that knowing about the impaired tolerance motivates patients to lose weight. There is also no evidence that oral hypoglycemic agents have a substantial long-term effect,[8,12] and their use would seem to be unwarranted for asymptomatic diabetes in view of the low rate of progression to frank diabetes and their lack of benefit in overtly diabetic populations.

Detection at the stage of asymptomatic diabetes has had no beneficial effect on morbidity or mortality in the Pima population[4] or in the population studies by the University Group Diabetes Program,[13] which led to the conclusion that "the UGDP findings provide no evidence that insulin or any drug lowering blood glucose levels will alter the course of vascular complications in adult-onset diabetes."

Properties of screening • The properties of screening include simplicity, acceptability, cost, precision, accuracy, specificity, sensitivity, and predictive value. The last three require definition:

1. Specificity is the percentage of disease-free individuals who are screened to be negative by the test.

2. Sensitivity is the percentage of individuals with disease who are screened to be positive by the test.

3. Predictive value is the percentage of positive or negative individuals who have disease or who are disease-free.

West[14] has outlined the sensitivity, specificity, and cost properties of various methods used in screening for diabetes (Table 1). As we have already indicated, a measured load of glucose applied under standardized conditions provides the greatest sensitivity and specificity but is obviously the most costly and difficult approach.

The WHO expert committee on diabetes mellitus in its second technical report stated that screening should always be accompanied by cost-benefit analysis.[15] This is rarely accomplished. In particular indirect cost to the individuals, work loss, and cost of additional medical care are seldom included. The direct costs alone for each new case of diabetes detected in screening programs were estimated by West[14] in 1978 to vary from $35 to $67 with indirect costs taking this well over $150. In 1985 dollars this figure would have to be doubled or tripled.

Advantages and disadvantages of screening • The advantages of screening include:

1. Opportunities for education of the public about diabetes.

2. Early detection before development of symptoms with possible prevention of morbidity and mortality from complications.

3. Prestige for the organizations involved in the screening program.

4. Fund raising opportunities for the organization providing the screening.

5. Research possibilities.

The preceding discussion has brought into question only the second point. It needs to be reemphasized that diabetes casefinding in pregnancy has specifically been excluded by our definition of screening as have studies of first degree relatives of youngsters with IDDM or early stages of diabetes.

The disadvantages of screening are:

1. Expense, both programmatic and individual.

2. Lack of evidence that early detection has an impact on long-term outcome in the population.

3. Limited resources for follow-up in many areas, raising the questions of cost-benefit and ethics of screening.

4. The psychological hazards of false positives.

5. The danger of missed diagnosis because of low sensitivity of the testing procedure (e.g., fasting blood glucose levels as noted previously).

Some of these factors can be altered by confining screening to particularly high-risk groups as was suggested by the Atlanta Workshop.[2] This would include the obese, those, with a family history of diabetes, nonpregnant individuals with an obstetrical history of large babies, those in high-risk populations such as Pima Indians or Blacks, and as part of studies of multiple risk factors in cardiovascular disease. By confining screening programs to high-risk populations, the advantages of screening are affected as follows:

1. Public education may be diminished for the public at large but increased for the population screened because of the greater concentration of effort.

2. Early detection with the possibility of preventive intervention might be enhanced by a more focused program.

3. The prestige of the reduced program is also likely to be reduced unless dramatic effects are demonstrated and can be publicized.

4. The fund raising potential of a focus on high-risk groups is reduced.

5. The research potential of a focused screening program should be enhanced.

In a program confined to high-risk groups some of the effects of screening would be:

1. Expenses would be reduced.

2. Intervention via early detection would probably be no better as evidenced by the lack of any evidence for improved outcome among Pima Indians despite extensive screening in that population.[13]

3. Although the limited resources for follow-up might be taxed, the higher yield in a smaller population might still make follow-up difficult.

4. The psychological effects of false positive tests would be similar in a high-risk group screening but would involve fewer individuals and could probably be dealt with more effectively.

5. Missed diagnoses due to false negative tests would be similar but fewer in high-risk group screening.

Conclusions • The recommendations of the Atlanta Workshop remain valid although they reflect a mixture of screening, casefinding, and diagnostic testing. The first recommendation was for "screening" among pregnant women which, as previously noted, is really casefinding as part of good obstetrical practice.

The second recommendation of the Atlanta Workshop was that screening programs to detect asymptomatic glucose intolerance per se are not recommmended as health services in nonpregnant populations.

The third recommendation was that screening for diabetes or its complications for research purposes should be done only as part of a well-designed focus on (a) identification of predictive factors, (b) cost effectiveness of the measures to lower risk factors, (c) descriptive epidemiology in selected populations, (d) operation of the medical care system, and (e) nature and effects of screening processes.

The fourth recommendation was that information and educational programs for health care providers, parents, and the general public should be implemented to bring about increased awareness of the clinical signs and symptoms of diabetes. This recommendation was offered as an alternative to the public education and promotion of diabetes programs thought to be an advantage of screening efforts.

The final recommendation of the Atlanta Workshop quite properly falls in the area of casefinding as well, that all persons known to have diabetes be evaluated regularly for the detection and management of the chronic complications of the disease.

In view of the very limited value of random blood testing for glucose as a means of detecting diabetes, such testing does not provide a public service.

References

1. Rosenbloom, A.L. and Allen, C.M.: Mass Urine Glucose Screening in Children, Metabolism 22(2):323-326, 1972.
2. Herron, C.A.: Screening in Diabetes Mellitus: Report of Atlanta Workshop, Diabetes Care 2:357-362, 1979.
3. National Diabetes Data Group: Classification and Diagnosis of Diabetes Mellitus and Other Categories of Glucose Intolerance, Diabetes 28:1039-1057, 1979.

4 Bennett, P.H.; Rushfortb, N B.; Miller, M., and LeCompte, P.M.: Epidemiologic Studies nf Diabetes in Pima Indians, Recent Progr Horm. Res. 32:333-371, 1976.
5. Rosentbal, M.; McMaban, C.A.; Stern, M.P.; Eifler, C.W.; Haffner, S.M.; Hazuda, H.P., and Franco, L.J.: Evidence of Bimodality of Two Hour Plasma Glucose Concentrations in Mexican Americans: Results from San Antonio Heart Study, J. Cbron. Dis. 38(1):S-16, 198S.
6. Sackett, D L. and Holland, W.W.: Controversy in Deteetion of Disease, Lancet ii:3S7-3S9, 196S.
7. National Center for Healtb Statistics: Plan and Operation of Second National Health and Nutrition Health and Nutrition Examination Survey 1976-80. Vital and Healtb Statistics Scries 1(1S)DHHS Publication N. (PHS)81-1317, Public Healtb Service, Wasbington, U.S. Government Printing Office, July 1981
8 Jarrett, R.J.; Keen, H.; Fuller, J.H., and McCartney, P : Worsening to Diabetes in Men witb Impaired Glucose Tolerance ("borderline diabetes"), Diabetologia 16:2S-30, 1979
9. Keen, H.; Jarrett, R.J., and McCartney, P.: Ten Year Follnw-up of Bedford Survey (1962-1972): Glucose Tolerance and Diabetes, Diabetologia 22:73-78, 1982
10. O'Sullivan, J.B. and Mahan, C.M.: Blood Sugar Levels, Glycosuria and Body Weight Related to Development of Diabetes Mellitus, JAMA 194:117-122, 196S.
11 Knowler, W.C.; Pettitt, D.J.; Savage, P.J., and Bennett, P.H : Diabetes in Pima Indians: Contributions of Obesity and Parental Diabetes, Am. J. Epid. 113:144-1S6, 1981.
12. Keen, H.; Jarrett, R.J., and Fuller, J.H.: Tolbutamide and Arterial Disease in Borderline Diabetics, Proc. VIII Congress Internatinnal Diabetes Federation, Malaisse, W.J. and Pirart, J (eds), Amsterdam, Excerpta Medica, 1973, pp. S88-602.
13. University Group Diabetes Program: Effects of Hypoglycemic Agents on Vascular Cnmplications in Patients witb Adult-Onset Diabetes, VII Evaluation of Insulin Tberapy, Final Report, Diabetes 31(Suppl. S):1-81, 1982.
14. West, K.M: Epidemiology of Diabetes and Its Vascular Manifestations, Elsevier (New York) 1978, pp. S4-67.
1S. WHO Expert Committee nn Diabetes, Second Report: Technical Report Series 646, World Healtb Organization, Geneva 1980.

Supported by contracts from the Department of Health and Rehabilitative Services of the State of Florida for Diabetes Centers at the Universities of Florida, South Florida, and Miami.

● Dr. Rosenbloom, Department of Pediatrics, Division of Endocrinology, University of Florida College of Medicine, Box J-296, JHMHC, Gainesville 32610.

Endorectal irradiation — conservative therapy for cure of early rectal cancers

Barry S. Tepperman, M.D. and Herbert E. Brizel, M.D.

ABSTRACT: Contact endorectal irradiation is a conservative, ambulatory treatment for early rectal cancers. In properly chosen patients, it offers cure rates comparable to radical resection while sparing the sphincters and surgical and anesthetic risks. In our experience, it is a well-tolerated, cost-effective and simple alternative to hospitalization and resection.

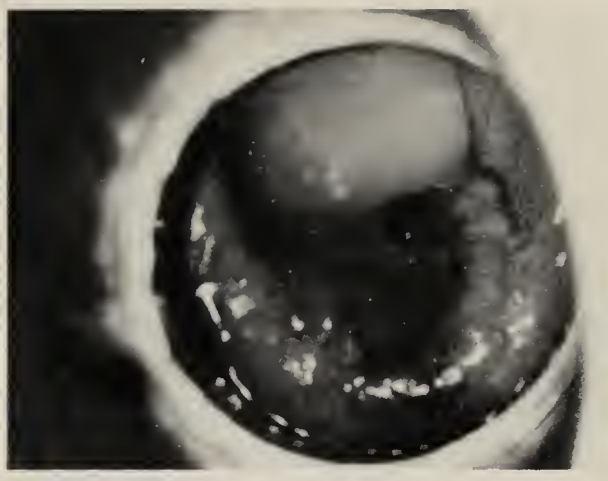
The Authors
BARRY S. TEPPERMAN, M.D.
HERBERT E. BRIZEL, M.D.
Drs. Tepperman and Brizel are with Memorial Hospital Regional Radiation Oncology Center, Hollywood, and also with the Division of Radiation Oncology, Department of Radiology, University of Miami, Miami.

Adenocarcinoma of the rectum is the third most common cause of cancer death in Florida.[1] The mainstay of curative management is surgical. For the patient who is medically inoperable or who is incapable of managing a colostomy, alternatives to surgery are indicated. These include local excision, cautery, and irradiation. All require strict clinical selection of patients most likely to benefit. Ideally a conservative nonsurgical treatment for rectal carcinoma should require neither hospitalization nor general anesthesia, have no intrinsic risk of mortality and a low risk of complication. It should avoid a colostomy and provide prospects of durable local control comparable to limited surgery. Finally it should not compromise surgical salvage in cases of failure.

Endorectal contact irradiation was developed in its present form by Professor Jean Papillon in France over 30 years ago.[2] North American experience dates from the late 1960s.[3,4] The "Papillon technique" satisfies all the above criteria and in properly selected patients offers both compliance and efficacy.

Therapeutic rationale • As demonstrated by local control with external radiation alone,[5] rectal adenocarcinoma is radiosensitive. However, the adjacent structures which must be included in the treatment volume for curative external irradiation of large or advanced lesions are also radiosensitive, and the high dose required to sterilize rectal cancer may cause unacceptable morbidity to the small intestine or bladder.[6]

A more tolerable treatment strategy requires a high radiation dose delivered to a precisely controlled limited volume. In endorectal irradiation the dose is delivered maximally on the surface of the tumor and



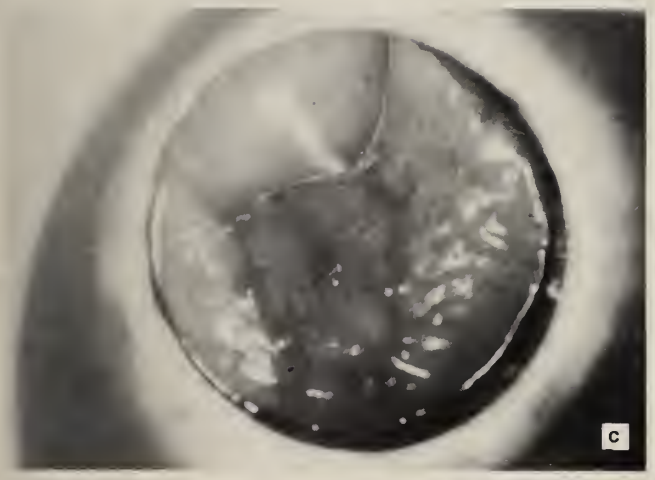


Fig. 1. — Regression of an exophytic lesion in response to endorectal irradiation: (a) before treatment; (b) after 2000 cGy; (c) after 4000 cGy; (d) after 6000 cGy; (e) after 10000 cGy (completed therapy).

decreases rapidly with depth in the rectal wall. While the visible lesion necroses during the course of therapy (5-6 fractions of 2000-3500 cGy each at 2 week intervals), the dose at depth increases progressively, ultimately sterilizing the tumor base Figs. 1a-e). The limited penetration limits the dose to the perirectal tissues, thus allowing uncomplicated surgical salvage of failures.

The Philips RT50 (Fig. 2) lends itself uniquely to this technique by emitting its beam from a narrow tip. Its 2 cm bore allows its introduction into a wide-bore rigid sigmoidoscope (Fig. 3) at a 4 cm distance from the tumor seen in the end of the sigmoidoscope.[7] The primary lesion can thus be treated to a total dose of 10000-12000 cGy over a period of 8-12 weeks to the full thickness of the rectal wall and a maximum diameter of 5 cm.

Patient selection • Identifying patients likely to benefit from this strictly local approach is difficult because the accepted prognostic system for rectal cancer requires surgical pathologic information.[8] Clinical methods to identify such patients have been systematized by Papillon on the basis of Morson's clinical-pathological correlations.[2,9] The essential criteria are lesion configuration, size, location, and multiplicity, pathologic grade, and fixation, and the presence of palpable perirectal nodes.

The ideal lesion for endorectal irradiation is a single polypoid, mobile, well-differentiated adenocarcinoma under 3 cm in diameter (risk of regional metastases<6%) located between 3 and 12 cm above

Fig. 2. — The Philips RT50 contact therapy unit.

the anal margin without palpable perirectal adenopathy. It presents an anticipated cure rate of 90-95%.[2] Poorly-differentiated or colloid adenocarcinomas present an excessive risk of regional spread (>25%). In lower-grade tumors the risk of nodal spread increases when the carcinoma is ulcerative or infiltrative, or with lesions larger than 3 cm. A fixed carcinoma — either clincally or by CT scan — penetrates too deeply to be sterilized by this superficial beam. Lesions which are multifocal, annular, greater than 5 cm in diameter or above the 12 cm level in the rectosigmoid physically exceed the curative capabilities of this modality. Lesions below the 3 cm level involve a significant risk of sphincter necrosis by irradiation. Palpable perirectal nodes are most frequently neoplastic and imply occult regional metastasis.

Fig. 3. — The Sischy treatment sigmoidoscope system[7] for endorectal irradiation.

Results • Papillon's most recent report,[2] with 280 patients treated radically, has a 5-year disease-free survival of 73.9% with only 11 patients (5.3%) failing in the primary site. Eight were successfully salvaged by surgery. Of 146 patients followed for ten years, there is a 58% disease-free survival with no local recurrences after the fifth year; 29.4% died of intercurrent disease, only 10% of cancer. Similarly, Sischy reports a 94% recurrence-free survival with a median follow-up period of 18 months in 94 cases;[3] Basrur's patients achieved an 87% disease-free survival.[4]

These control rates equal or exceed those for fulguration or cryosurgery and rival those reported for optimal local excision or radical surgery for stages A-B_1. They surpass the best results of definitive external beam radiation.[5]

Endorectal irradiation also palliates discharge, bleeding, and pelvic pain from sites within reach of the treatment proctoscope in 80% of patients beyond cure, without significant morbidity even when maximal external irradiation had been given.[3] It is also a valuable adjuvant post-polypectomy for control of large recurrent villous adenomas of borderline histology.[2,3]

Eight patients have been treated radically in the first year of our endorectal irradiation program, all over age 70 and medically inoperable. Three patients were treated after failure of other conservative modalities. All lesions were mobile, exophytic, and well- or moderately-differentiated. Other than transient hypotension related to premedication in two cases, tolerance to therapy was excellent. Seven lesions regressed completely by the fourth fraction. Seven patients were rendered locally disease-free; one failed locally and was salvaged at eight months. One patient treated for recurrence in a defunctioned rectal stump developed hepatic metastases at nine months and subsequently died. A ninth patient with an anastomotic recurrence low in the rectum and coexisting liver metastases was treated palliatively; because of the bulk of tumor, only partial control was achieved but an abdominoperineal resection was avoided.

Treatment techniques • Routine pretreatment evaluation by the radiation oncologist includes sigmoidoscopy, liver function studes and CEA determinations. A double-contrast barium enema is performed and pelvic CT scan to assess both lesion thickness and possible occult spread.

Patients are prepared with either polyethylene glycol-electrolyte osmotic lavage or enemas. Meperidine and intravenous diazepam are given in the outpatient holding area, and the patient is placed on a sigmoidoscopy table in jackknife position. After a rigid sigmoidoscopy to locate the lesion and assess response, the rectum is progressively dilated to 4 cm using either topical anesthesia with xylocaine viscous or additional diazepam. The applicator is held firmly in place against the lesion under direct vision; the tip of the x-ray tube is docked into the applicator and treatment is given over 2-3 minutes for 2000-3500 cGy.

Radiation safety precautions are those required for diagnostic x-ray units. Regular lead aprons and gloves are used by the radiation oncologist and technologist and the metal applicator defines the beam to protect normal surrounding tissues.[7]

Rectal discomfort or discharge and occasional hematochezia can occur between treatments. These respond well to conservative measures such as topical steroids. The treated rectal wall ultimately becomes fibrotic with telangiectasia and atrophy of the mucosal surface. Our patients are encouraged to use stool softeners and maintain a high-fiber diet to prevent the rare occurrence of intermittent bleeding after straining. Because of fibrosis and atrophy, a biopsy site may ulcerate; areas suspicious of recurrence should be biopsied with caution. A superficial cytologic specimen may suffice to document recurrence. Apart from direct sigmoidoscopic follow-up at 8-12 week intervals, CEA, barium enemas, and colonoscopy are performed at appropriate intervals.

Acknowledgements

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References

1. State of Florida, Department of Health and Rehabilitative Services, "Cancer In Florida — 1981", Tallahassee, 1985, pp. 25-28.
2. Papillon, J.: Rectal and Anal Cancers; Springer-Verlag, Berlin, 1982, pp. 3-105.
3. Sischy, B.; Graney, M.J., and Hinson, E.J.: Endocavitary Irradiation for Adenocarcinoma of Rectum, CA 34:333-339, 1984.
4. Basrur, V.R. and Knight, P.R.: Intracavity Radiation for Rectal Carcinoma, J. Can. Assoc. Radiol. 34: 43-46, 1983.
5. Cummings, B.J.; Rider, W.D.; Harwood, A.R.; Keane, T.J., and Thomas, G.M.: Radical External Beam Radiation Therapy for Adenocarcinoma of Rectum, Dis. Colon Rectum 26: 30-36, 1983.
6. Cohen, A.M.; Gunderson, L.L., and Welch, C.E.: Selective Use of Adjuvant Radiation Therapy in Resectable Colorectal Adenocarcinoma, Dis. Colon Rectum 24: 247-251, 1981.
7. Bramlet, R.; Tobochnik, N., and Sischy, B.; Endocavitary Contact X-Ray Applicator System for Treatment of Rectal Carcinoma, Brit. J. Radiol. 58: 147-149, 1985
8. Gunderson, L.L. and Sosin, H.: Areas of Failure Found at Reoperation (Second or Symptomatic Look) Following "Curative Surgery" for Adenocarcinoma of Rectum, Cancer 34: 1278-1292, 1974
9. Morson, B.C.: Factors Influencing Prognosis of Early Cancer of Rectum, Proc. Roy Soc. Med. 59: 607-608, 1966.

- Dr. Tepperman, 3501 Johnson Street, Hollywood 33021.

Technetium 99m MDP uptake in drug-induced fibrous myopathy

Bruce A. Rodan, M.D., William J. Bean, M.D., and David Mullin, M.D.

ABSTRACT: Bone scanning agents are known to accumulate within various nonosseous structures. We present a case of soft tissue uptake of Technetium 99m MDP in a drug abuser. Chronic intramuscular injections of pentazocine and meperidine led to muscular fibrosis with dystrophic calcification. The clinical features of pentazocine-induced fibrous myopathy are presented.

The Authors
BRUCE A. RODAN, M.D.
WILLIAM J. BEAN, M.D.
DAVID MULLIN, M.D.
Drs. Rodan, Bean and Mullin are Staff Radiologists at the Palm Beach-Martin County Medical Center, Jupiter.

Bone scanning agents are known to accumulate within various nonosseous structures. Soft tissue changes may be manifest on radionuclide bone scans. Increasing drug abuse has led to a heightened awareness of certain rheumatic complications. We present a case of soft tissue uptake of Technetium 99m MDP in a patient with pentazocine and meperidine-induced fibrous myopathy.

Case Report • A 43-year-old white married female was evaluated for a chronic pain disorder. Historically her complaints were of 14 years' duration when a nephrotic syndrome developed. A renal biopsy was consistent with healed immune complex glomerulonephritis, membranous type. A diagnosis of relapsing polychondritis was obtained from a left ear cartilage biopsy. She was treated with cortisone and immunosuppressive drugs. Subsequent complications of this therapy included peptic ulcer disease, aseptic necrosis of the right hip requiring a prosthetic implant, and a lumbar compression fracture.

The onset of the pain disorder was reportedly coincidental with numerous major stress-provoking life events. The pain was described as a dull ache mostly experienced in the nose and ears as well as in the arms and low back. The major complaints were mostly psychological, such as sleep disorder, self-destructive thoughts and preoccupation, and massive weight gain. She also suffered from chronic hypochondriasis with multiple substance use disorder. The patient stated she was on pentazocine (Talwin) 10-15 cc IM daily and meperidine (Demerol) up to 400 mg IM daily prior to evaluation.

The most striking findings on physical examination were areas of induraton involving the deltoid, gluteal and quadriceps muscles. These corresponded to sites of self-administered intramuscular injections. No cutaneous abnormalities or neurologic changes were present.

A radionuclide bone scan (Fig. 1A,B) was performed following the injection of 20 millicuries of Technetium 99m MDP. This revealed areas of diffuse, symmetrical uptake in the soft tisues of the arms, buttocks and thighs. Radiographs of these areas revealed a few scattered fine calcifications within the soft tissues. No bony lesions were seen. The

Fig. 1A. — 99m Technetium MDP scan of right upper extremity reveals soft tissue uptake in the deltoid muscle. Similar uptake was present in the left arm.

Fig. 1B. — Scan of both thighs reveals soft tissue uptake in both quadriceps muscles. These corresponded to areas of induration from intramuscular drug injections.

radiopharmaceutical uptake directly corresponded to the sites of induration, a fibromyositis caused by chronic pentazocine and meperidine injections.

Discussion • Bone scanning agents are known to concentrate in various nonosseous structures.[1-3] The mechanism of action is uncertain. Whether persistent accumulation or exchange with calcium in abnormal tissue or some other alteration of soft tissue is responsible for Technetium uptake in dystrophic calcification is not known.[4] Technetium 99m MDP accumulates in areas of bone accretion; however, with dystrophic calcification there are no associated osteoblasts and the mechanism may be different. Some derangement of calcium and phosphate metabolism is a common finding in extraosseous uptake.[1] Technetium agents can localize in soft tissue lesions which have an active transport of calcium and/or phosphate.[5] Radioisotope techniques are more sensitive than radiographs for the detection of bone abnormalities and this might be true for some soft tissue diseases which produce extraskeletal ossification.

The mechanisms by which chronic intramuscular injections lead to muscle fibrosis are not completely understood. Although it is hypothesized that pentazocine,[6,7] and meperidine[8,9] may be the offending agents, repeated needle trauma in itself may explain the process. Chronic focal infection or chemical irritation by the drugs themselves may establish chronic inflammation which stimulates fibroblast proliferation.[10]

In pentazocine-induced fibrous myopathy, muscle biopsy shows extensive fibrosis of the skin and muscle with scattered collections of lymphocytes, frequently around vessels, areas of calcification and focal areas of atrophied muscle fibers.[7] The most characteristic finding is fibrotic induration in the quadriceps and deltoid muscles, the common sites of injection. There is considerable limitation of motion due to fibrotic muscle contracture; however, only minimal weakness of involved muscles is noted. Distinctive cutaneous features, which are not found in all patients, include (1) the tense, woody, expansive fibrosis that extends well beyond the sites of injections, (2) the irregularly shaped deep ulcers, often deep enough to expose the muscle, (3) a halo of pigmentation around the ulcers, and (4) a distinctive lack of pain despite the indolent process.[11]

Extraosseous localizations of Technetium bone scanning agents are commonly encountered. Normal physiologic sites include the kidneys and cartilage. Common artifacts are free pertechnetate in the thyroid or stomach, activity at the injection site or due to urine contamination. Areas of dystrophic calcification may also be encountered in tissue injury, degeneration or necrosis. This is increasingly seen in intramuscular narcotic drug abuse, illustrated by our case of pentazocine and meperidine-induced fibrous myopathy.

References

1. Desai, A.; Eymontt, M.; Alavi, A., et al: 99m Tc-MDP Uptake in Non-osseous Lesions, Radiol. 13S:181-184, 1980.
2. Heck, L.L.: Extra-osseous Localization of Phosphate Bone Agents, Semin. Nucl. Med. 10:311-313, 1980.
3. Spencer, R.D., and Datu, J.A.: Bilateral Lower Limb Uptake of Bone Scanning Agents, Semin. Nucl. Med. 10:314-316, 1980.
4. Epstein, D.A.; Solar, M., and Levin, E.J.: Demonstration of Longstanding Metastatic Soft Tissue Calcification by 99m Tc diphosphonate, Am. J. Roetngenol. 128:14S-147, 1977.
5. Suzuki, Y.; Hisada, K., and Takeda, M.: Demonstration of Myositis Ossificans by 99m Tc Pyrophosphate Bone Scanning, Radiol. 111:663-664, 1974.
6. Steiner, J.C.; Winkelman, A.C., and de Jesus, P.V.: Pentazocine-Induced myopathy, Arc. Neurol. 28:408-409, 1973.

7. Oh, S.J.; Rollins, J.L., and Lewis, I.: Pentazocine-Induced Fibrous Myopathy, JAMA 231:271-273, 1975.
8. Aberfeld, D.C.; Bienenstock, H.; Shapiro, M.S., et al: Diffuse Myopathy Related to Meperidine Addiction in Mother and Daughter, Arch. Neurol. 19:384-388, 1968.
9. Mastaglia, F.L.; Gardner-Medwin, D., and Hudgson, P.: Muscle Fibrosis and Contractures in Pethidine Addict, Br. Med. J. 4:532-533, 1971.
10. Johnson, K.R.; Hseuh, W.A.; Glusman, S.M., et al: Fibrous Myopathy, Rheumatic Complication of Drug Abuse, Arth. Rheum. 19:923-926, 1976.
11. Parks, D.L.; Perry, H.O., and Muller, S.A.: Cutaneous Complications of Pentazocine Injections, Arch. Derm. 104:231-235, 1971.

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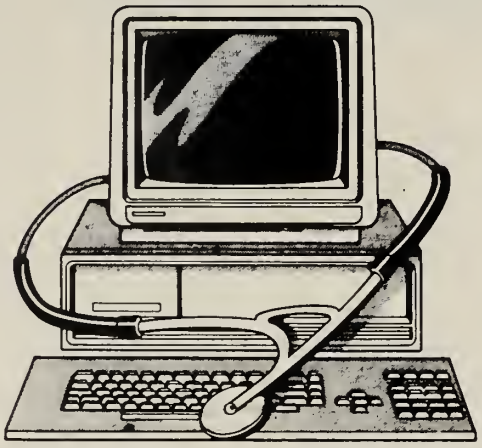

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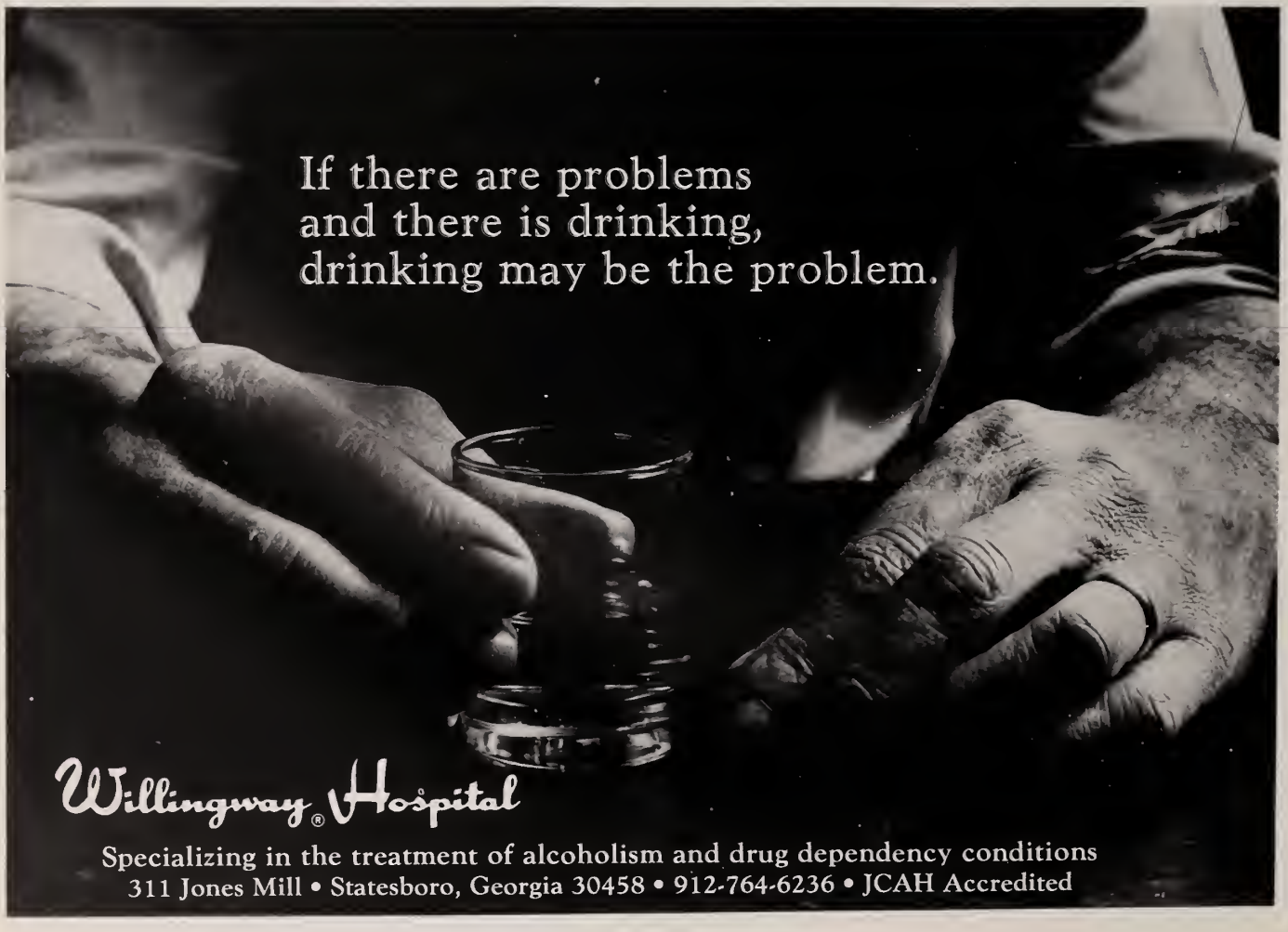

The academic medical center as an endangered species

The financial viability of medical academic institutions is being threatened. The decrease in inpatient hospital census, the limited funds available for caring for the more severely ill imposed by DRGs, and the proposed cutbacks of subsidies for medical education by government and private insurance companies may severely disrupt the structure of our medical centers.[1]

Many practicing physicians will approach the plight of the academic centers with avid apathy; after all, they feel burdened with their own difficulties such as problems with Medicare reimbursement, encroachment on their own patient numbers by HMOs and PPOs, and the myriad other harassments associated with private practice. Lack of concern for our medical centers is inappropriate. Let us not forget that the academic centers birthed, nourished, protected, and even supported some of us during our professional infancy. Let us not forget that most of the procedures we perform, the specialized skills we have obtained, and the scientific knowledge that sustains us in our practice have emanated from teaching institutions. The strangulation of medical academe will foster the professional stagnation and decay of the practitioner. Organized medicine must provide political, moral, and economic support of our teaching institutions.

Medical centers have burgeoned in size and number during the past half century. They have evolved from depression-vintage institutions that primarily cared for large numbers of indigent patients, that were served by a large voluntary staff and a few full-time faculty, and in which clinical research was performed on a part-time basis by a select few investigators. They have evolved into institutions that compete with all other hospitals for patients from all strata of society. Their faculties are usually full time and number in the hundreds. The research budgets of the large centers mount into the tens of millions of dollars. The number of medical schools has increased from 86 to 127 in the last fifteen years and their student enrollment has swelled from 21,000 in 1960-61 to 67,000 in 1984-85. This evolutionary growth resulted from the serial input and convergence of several programs that were introduced after World War II. In 1945 and 1946, the Veteran's Administration Hospitals forged links with academic health centers. This action provided care for veterans and support for residency training. In the 1950's, Congress opened the financial spigots to promote biomedical research. In the 1950's and 1960's, hospital insurance was extended to the majority of families of employed individuals and this provided monies for patient care. State support of new medical schools provided resources for capital and operating expenses in the 1960's and 1970's. At the same time, the Medicare and Medicaid programs were introduced. These provided additional funding for elderly and indigent care and secondarily for medical education. Finally, in 1971, capitation grants were legislated for the training of additional medical and other health professional students.

The blizzard of new monies that has fallen upon the academic centers in the past forty years has created an academic health care system unsurpassed anywhere in the world. However, this evolution has also produced a predicted surplus of 70,000 physicians by 1990 and 145,000 physicians by the year 2,000. This surfeit of physicians has received some of the blame for the escalation in health care costs in

the 1970's and 1980's. The surplus has also encouraged government and private health care payers to decree that they will no longer reimburse academic medical centers for that portion of medical care charges that can be attributed to medical education. Since patient care income now provides the largest single source of funding for academic health centers (about one-third of their budgets) a significant reduction in patient care reimbursement will certainly upset the fragile financial stability of most centers.

Teaching institutions are lumbering behemoths that are especially vulnerable to the present salvos of economic mutation. Individual practitioners, whole group practices, large clinics, and even private hospitals can respond to economic and demographic change by relocating or by rapidly altering their administrative or financial structures. Teaching institutions lack these elastic adaptive mechanisms because they are so different. The complexity of their mission is different, i.e., they have teaching and research functions to perform in addition to their patient care responsibilities. Their financing is different, i.e., they are pathetically dependent on federal and state governments for their survival. Their governance is different; it is encrusted by burdensome regulations imposed by granting agencies and state governments that severely stifle the managerial innovation necessary for survival in today's harsh economic environment.

Teaching centers may suffer greatly but they will not succumb to a dinosaur-like extinction. They have always survived crises before. Inner cities have thrived, decayed, and revived again as have political and sociologic trends. Through all of this, the great teaching institutions have endured as sphinx-like edifices that watch over the human bustle about them. Their buildings may have been given external facelifts and internal amputations and transplantations. Dilapidated structures have been torn down and new ones erected but the spirit of the institutions has remained intact. Energized by the continual ingress and efflux of countless bright and highly motivated minds, they have percolated with an exhilarating rhythm that has invigorated all of medicine. This cadence may be temporarily asynchronous with today's political and economic pulsations. However, the great centers will prevail through this current difficulty. Hopefully, they will not be so injured that it will require decades for their recuperation. We need to recognize these unique difficulties being experienced by our teaching institutions.

For this reason, I have asked Dr. Knapp and Dr. Bentley to write the appended paper "Understanding the Challenge Facing Teaching Hospitals." Dr. Knapp is Director and Dr. Bentley Associate Director of the Department of Teaching Hospitals of the Association of American Medical Colleges.

References

1. Ginzberg, E.: Academic Health Centers Troubled Future Health Affairs (Summer 1985) 5-21.
2. Relman, A.: Who Will Pay For Medical Education In Our Teaching Hospitals? Science Vol. 226; 220-223, 1984

Jacques R. Caldwell, M.D.
Daytona Beach

Understanding the challenge facing teaching hospitals

Contemporary American teaching hospitals are among our nation's most complex enterprises. They combine many of the characteristics of community general hospitals, specialty referral centers, social service and welfare agencies, educational institutions, and research institutes. These characteristics are combined in many different ways in individual teaching hospitals depending upon the hospital's mission, its role in the community, the resources available to it, its past history, and its view of the future. The characteristics also vary with the hospital's relationship to the medical school. Depending on the definition used, the number of hospitals classified as teaching hospitals varies dramatically. For example there are only sixty-one hospitals under common ownership with a college of medicine. There are an additional fifty to sixty hospitals where the majority of medical school department chairmen also serve as the hospital chief of service. Four hundred and thirty hospitals belong to the Council of Teaching Hospitals of the Association of American Medical Colleges (AAMC). An estimated 1,100 hospitals have some type of affiliation with a medical school, and about 1,350 hospitals participate in at least one residency program.[1]

However, it is not difficult to characterize the financial environment and risks facing teaching hospitals. The financial environment for hospitals has changed dramatically in the past five years. While hospitals once competed primarily on the breadth of their missions and the scope of services provided to support practicing physicians, they now compete increasingly on the basis of price.

Many health care payers are currently experimenting with a variety of approaches that will allow them to spend their health care dollars "more wisely." These payers have attempted to find out precisely what they are being charged and to restrict themselves to paying for only those goods and services they believe are necessary and reasonable for the care of their patients. They then negotiate the most favorable price they can for those goods and services.

Some payers have defined the services they will buy as those necessary for the total health of their insured population, and they have developed or entered into a capitated arrangement, frequently a health maintenance organization (HMO). Others have retained the more traditional fee for service model, but they have sought to change how those services are purchased by setting prices or engaging in competitive arrangements to encourage efficient, low cost delivery of services. The best known arrangements to set prices for services delivered is Medicare's Prospective Payment System which redefines the unit of service delivered as all hospital care rendered to a patient during a hospital admission and pays a fixed price based on the patient's diagnosis. Other fixed price arrangements have been established by law or negotiated by large insurors to pay for hospital care on a per case or patient day basis. In other instances, large scale purchasers of health services have been able to create preferred provider arrangements to achieve price discounts from hospitals.

"Cost shifting" is a term that has been used to describe the circumstances when a patient is provided services, and the cost of caring for that patient is met through increased charges to other patients. The term cost shifting has been used primarily in discussions of uncompensated care. However, there are other types of cost shifting that do occur in hospital financial arrangements. They are more commonly referred to as cross subsidies, but the principle is the same.

Price competition threatens teaching hospitals because they historically have supported, or cross-subsidized, four special services with patient care revenues from routine patients. The subsidized services and/or products have included: (1) clinical education in the health sciences; (2) clinical research and applied technology; (3) regional standby and tertiary services; and (4) uncompensated care.

As price competition requires teaching hospitals to reduce charges for routine services to paying patients it is unclear how the costs of these special services will be supported in the future. In this circumstance, it is important to understand the special services of teaching hospitals and the added costs of offering these services.

Clinical education • Teaching hospitals are major educational institutions. In 1985, teaching hospitals provided the training sites for over 80,000 residents and fellows in graduate medical education programs, over 30,000 students in the last two years of medical school, and large numbers of nurses and allied health professionals. The clinical education of medical, nursing and allied health students is organized around the daily operations of the hospital. Patients are being treated and students are being trained through the same activities. In effect, both products — patient care and education — are being simultaneously, or jointly, produced. The joint product nature of patient services and clinical education does not imply that education is being produced without additional costs — education is not simply a byproduct. The addition of the educational role does involve additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. It is most difficult, however, to identify distinctly many of the educational costs because of the impossibility of a clear separation of clinical care and clinical education.[2] It is also difficult to quantify the service benefits teaching hospitals receive from physicians, nurses, and allied health professionals in training programs.

Residents learn clinical skills through supervised participation in the diagnosis and care of patients. The patient service benefits that accompany this learning reduce, in some part, the costs of graduate medical education programs. The cost reduction varies with the patient's clinical needs and the resident's level of training. Service benefits provided by residents are probably more substantial for tertiary care patients requiring continuous medical supervision than for routine patients and are greater for senior residents than junior residents. While there is no conclusive study comparing the costs added by residency programs with the service benefits provided by residents, hospital executives and medical educators generally believe that the costs of operating a residency program exceed the service benefit obtained by patients. This added cost is the investment necessary to adequately prepare the future generation of professional health personnel.

Clinical research and applied technology • In the past four decades, the medical sciences have made dramatic advances in diagnosis and treatment. Much that is now widely available was unknown a generation or two ago. Many of these advances began in the basic reasearch laboratories of universities and their affiliated hospitals; most of the advances were transferred to patient care as clinical research programs at teaching hospitals.

The reputation of teaching hospitals for state-of-the-art medical care is world-renowned but difficult to quantify. Hospital industry surveys generally do not inquire about new, rare or unique services. Occasionally, a national inventory does provide some insight. For example, in 1980, the U.S. Public Health Service published a list of clinical genetic service centers. Of the 223 listed centers, 82 were hospital programs with 57 of these (70%) sponsored by members of the Council of Teaching Hospitals. An additional 36 programs were located in state

agencies, private health agencies, and private research institutes. The largest concentration, 105 programs, was located in universities, but in these university programs, the roles of their teaching hospitals were not separately identified.

The clinical genetics data illustrates the problem of identifying the teaching hospital's role in clinical research. In many cases, the university's faculty are also the hospital's medical staff. The specific identification of research program location may reflect more upon the flow of grant funds (e.g., National Institutes of Health to university) than on the actual site of the research (i.e., university of hospital). Data on clinical research derived from funding flow typically understates the teaching hospital's role.

The hospital's role is also understated in published research. While the investigator may be conducting his or her research activities in the hospital using its laboratories and studying its patients, citations in the publication of a research article often relate more to academic advancement than to enhancing prestige in patient care. As a result, authors of clinical studies performed in the hospital generally list the university where they have faculty rank rather than the hospital where they have admitting privileges.

The presence of medical research in the teaching hospital has environmental, managerial, and financial implications. To attract and retain research-oriented faculty physicians, the hospital must create and maintain a climate conducive to research: research scholarship must be esteemed, research support and supplies must be readily available, and individual hospital departments must be flexible and responsive to the demands accompanying research. Managerially, the inclusion of medical research in a teaching hospital's primary mission requires governing board and senior management commitment to integrating research into the daily operations of the hospital: specialized supporting staff must be hired and trained, necessary research review and patient protection procedures must be developed and monitored, record-keeping and reporting required by the funding organization must be established, and management styles appropriate for personalized and efficient patient care must be balanced with a collegial style appropriate for research productivity.

Establishing a medical research program increases a teaching hospital's costs. Additional costs are incurred for staff, supplies and equipment, space, maintenance and upkeep, and record-keeping. Most but not all of these added costs are supported by grants, contracts, endowments, and gifts. Regular hospital services provided for research patients are generally paid by the patient or his third party coverage. However, the definition of routine care for patients on research protocols is an issue which requires discussion. Many elements confound the ability to conduct an acceptable study to determine the extent to which services provided according to a research protocol cost more than care for the same diagnosis in the absence of a research protocol.[3] Points that need to be considered are as follows:

(1) The difficulty of isolating procedures and therapies ordered and performed under research protocols from those that could occur under a routine or standard regimen, and identifying their specific costs.

(2) Identifying clinical trial patients and a matched control group for comparative purposes presents dilemmas. In many diseases for which research is conducted there exists no generally accepted treatment.

(3) Clinical trials vary in complexity, from testing the dosage and administration of drugs to the use of new technologies, therapies or invasive procedures.

(4) Involvement in clinical trials may be related to consideration of the complexity of stage of illness. In other words, research participation may be focused on the sicker patients. This would establish a further degree of difficulty in isolating research-related costs, due to the lack of agreement as to how severity measures can be imposed as evaluative criteria.

(5) Care must be given to agreement on the time frame acceptable for comparison of research and non-research related costs of care. Clinical trial paritication may be of short duration, extend over several years, require inpatient or outpatient follow-up, or extended or shortened nursing time due to drug administration.

There is much about this subject which is not well understood. However, without an appropriate environment as well as managerial and financial support, clinical research will not flourish.

Regional standby and tertiary care services • The teaching hospital's patient care reputation is clear; it is the place for the most severely ill patients. Teaching hospitals are the primary source of microsurgery, joint replacement surgery, transplant surgery, specialized laboratory and blood banking services, and specialized neurological and opthalmologic procedures, to name a few. Patients with the most severe medical needs tend to be sent to teaching hospitals for the latest care capabilities.

While the charges for many teaching hospital services are related to the costs of providing them, there are some services for which special charges are not made, or charges are not set high enough to cover full costs. For example, at many medical center hospitals, services are provided to a very substantial number of high risk pregnant women. The cost of providing services to these women is substantially higher than the cost of providing ser-

vice to a woman whose pregnancy is without substantial risk. In most hospitals the charges for services to these two groups of women are substantially the same. However, the costs of providing these services are quite different. In effect, the patient with extensive needs is being subsidized by the patient with routine needs since the charges and costs are based on "averages." In a market where patients are sensitive to hospital prices, the teaching hospital is therefore at a disadvantage.

To survive in the evolving medical marketplace, teaching hospitals will lower their prices for routine services and will begin to price services for standby services and other tertiary care services at a rate which is related more clearly to the cost of providing such services. Thus, the public will have to become used to paying much higher prices for these services, and the price of these services may rise rather dramatically in the short run.

Uncompensated care • Because of the long and distinguished history of hospitals such as Jackson Memorial Hospital in Miami, Bellevue Hospital Center in New York City, and Cook County Hospital in Chicago, many individuals perceive the non-Federal members of the AAMC's Council of Teaching Hospitals (COTH) as "charity care teaching hospitals." Charity care and medical education are assumed by some to be necessarily interdependent objectives of major medical centers. There is some validity to this perception. First, in 1980, non-Federal COTH members, which comprise 6% of the nation's community hospitals and 18% of its admissions, incurred 35% of the bed debts and 47% of the charity care. Secondly, many municipally-sponsored "charity" hospitals historically have had difficulty recruiting an adequate number of physicians. To provide appropriate and necessary medical services to their patients, those hospitals have often affiliated with local medical schools to obtain the professional medical services which are provided by residents training under faculty supervision. These affiliation arrangements have benefitted both the patients receiving care and the physicians receiving supervised training. Thirdly, when states and municipalities have authorized appropriated funds to help finance hospitals with disproportionate charity care populations, the funding has sometimes been given an educational label to either increase its political acceptability or to channel it to particular hospitals. These three relationships between teaching hospitals and charity care have left many in our nation with the stereotypical view that the terms "teaching hospitals" and "charity care hospital" are synonymous.

This perception is not completely accurate, and its perpetuation can hamper appropriate discussions of the options for addressing uncompensated care. It should be noted that the uncompensated care burden of teaching hospitals is bimodal: some teaching hospitals, both publicly owned and not-for-profit, provide vast amounts of uncompensated care but many provide an amount comparable to non-teaching, non-profit hospitals. Secondly, it must be recognized that medical students and residents can be trained without charity care patients. Therefore, if the issue of uncompensated care is to receive the attention it deserves, the issues of uncompensated care and medical education need to be separated.

There are at least seven primary concentrations of uncompensated care: (1) obstetrical and pediatric patients; (2) chronically ill patients repeatedly admitted; (3) patients awaiting placement in a less than acute care setting; (4) patients admitted for catastrophic medical services such as burn or trauma care; (5) uninsured patients including the unemployed and illegal aliens; (6) patients who have abused drugs and alcohol; and (7) insured patients unable to pay copayments and deductibles.

In individual teaching hospitals, the mix of these seven types of patients varies substantially.

Many teaching hospitals have provided care for economically disadvantaged patients for decades. Prior to Medicare and Medicaid, much of that care was organized into charity clinics and housestaff wards. Since 1965 and the national commitment to "mainstreaming" indigent patients, teaching hospitals have made substantial strides toward replacing two classes of care with a single class of care.

Some teaching hospitals have provided a community-based "safety-net" for the medical needs of the poor and medically indigent by offering extensive ambulatory and emergency services. Teaching hospitals have been able to do this because some were assisted with tax revenues and some were assisted with philanthropy, but most subsidized uncompensated care through higher charges to charge paying patients.

Conclusion • Teaching hospitals are a diverse group of highly complex institutions performing medical education and research services for the nation and providing both basic and tertiary patient care. The current emphasis on price competition places teaching hospitals and their vital activities at significant risk if their special nature and role are not appreciated. As policies and expectations change, teaching hospitals will continue to adapt and evolve. If developing policies on health care delivery and payment recognize and support financially and distinctive characteristics and diversity of teaching hospitals, their fundamental missions can be preserved. If the characteristics of teaching hospitals are not recognized and valued, simplistic policies may damage the ability of these institutions to fulfill their multiple responsibilities.

References

1 Liason Committee on Graduate Medical Education, Directory of Accredited Residencies, 1985-86, Chicago.
2. Medical Education Costs in Teaching Hospitals: An Annotated Bibliography, Association of American Medical Colleges, April, 1985.
3. Karen Pfordresher, "Clinical Research and Prospective Payment," COTH Report, January 1985.

James D. Bentley, Ph.D.
Associate Director
Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
Association of American Medical Colleges

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NOTES & NEWS

Palm Beach County Chapter of Heart Association funds new Schiebler Chair in Pediatric Cardiology

A $600,000 donation from the Palm Beach County Chapter of the American Heart Association (AHA) will fund the establishment of an Eminent Scholar's Chair in pediatric cardiology at the University of Florida.

Representatives of the chapter presented the gift on November 8 to UF President Marshall Criser and Dr. William B. Deal, dean of the College of Medicine, during a press conference at the chapter headquarters in West Palm Beach.

Honored during the program was UF administrator and pediatric cardiologist Dr. Gerold L. Schiebler, for whom the endowed chair is being named. Dr. Schiebler recently assumed a new administrative position as associate vice president for health affairs for external relations at the UF Health Science Center. He is in his 25th year with the UF pediatric faculty and has served 17 years as chairman of the Department of Pediatrics. He also has become known as "the children's friend in the Florida Legislature" after attending more than 10 legislative sessions in Tallahassee to lobby support for children's health programs.

Joseph B. Shearouse Jr., president of Fidelity Federal Savings Bank in West Palm Beach and chairman of AHA's local Eminent Scholar Chair Committee, said, "Establishing a teaching chair in Dr. Schiebler's honor is a great opportunity for the Palm Beach County Chapter to continue contributing to the advancement of cardiac care. Endowing the chair is a high point for this chapter, now in its 34th year."

In addition to the Schiebler Chair, the chapter also contributed $600,000 in 1984 for an Eminent Scholar's Chair in adult cardiology. . .a position for which more than 60 scientists have been nominated. Outstanding candidates are now being selected for interviews at UF.

Schiebler was cited during the presentation ceremony for his numerous contributions to significant improvement of Florida medical services for infants, children and their families. He has worked with Florida pediatricians and state government to bring about legislation that resulted in development of a statewide program for children with rheumatic heart disease, and a statewide network of neonatal and perinatal intensive care units; as well as regional screening programs for infant hearing problems, curvature of the spine, kidney disease, genetic abnormalities, and metabolic disorders.

A more recent result of his lobbying effort was the establishment of the Child Protection Teams now serving the entire state through the Department of Health and Rehabilitative Services (HRS).

Schiebler has been an active volunteer supporter of the American Heart Association for 21 years, and in 1979, he won the association's highest award. . . the Distinguished Service Medallion.

His contributions to pediatric cardiology include establishing the nation's first training program (at Shands Hospital) for cardiovascular technicians to staff cardiac catheterization laboratories; the compilation of updated information on heart disease for the first international Birth Defects Atlas and Compendium, published in 1973; serving on the cardiac advisory committee for the state; contributing to several leading textbooks in pediatric cardiology; and developing comprehensive diagnostic, medical and surgical services for Florida children with congenital heart disease.

"Having the new endowed teaching positions in adult and pediatric cardiology will help UF produce more highly skilled professionals for cardiac patients of all ages," Schiebler said. "The care of children with heart disease varies significantly from that of adults because many heart defects found in children are present at birth and demand immediate attention. Most adult heart problems are a result of aging and lifestyle."

Other UF officials attending the presentation were Dr. David R. Challoner, vice president for health affairs; Alvin V. Alsobrook, vice president for university and government relations; Dr. James E. McGuigan, professor and chairman of the Department of Medicine; Dr. Richard T. Smith, vice president for advancement; and Gerald H. Eidson, associate in medical program development. Members of the AHA's Eminent Scholar Chair Committee include Bill R. Brown, John S. Hughes, Dr. Istvan Krisko, Dr. Thomas F. Raymond, and Dr. Donald E. Warren.

Nationwide eye care project launched for the elderly

A nationwide public service project will provide medical and surgical eye care to America's elderly, regardless of their ability to pay.

Sponsored by the Foundation of the American Academy of Ophthalmology, the project is called the National Eye Care Project. It begins January 6, 1986, in Washington state, and will be phased in nationwide in two- to three-week intervals in twelve multistate regions. Implementation in Florida begins March 17, 1986.

The project will operate in this fashion: if a person is age 65 or older, is an American citizen or legal resident, and does not have a personal ophthalmologist, he or she may call a toll-free number for assistance. An operator, using a computerized system, will match the caller with a nearby ophthalmologist who has volunteered to provide care.

The project's emphasis is on the needy. If a patient does not have Medicare or other health insurance — and 4 to 5% (more than one million) of elderly Americans do not, for whatever reason — then the physician's services are provided without charge.

If the caller has Medicare or other health insurance, this will pay the entire cost of the physicians's services. For this project only, volunteer ophthalmologists have agreed to accept Medicare and insurance assignment as payment in full.

The Foundation wants to reach as many of these needy elderly Americans as possible. Cataracts, glaucoma, diabetes and other conditions affecting vision need to be detected and treated promptly. In a pilot test of the project, ophthalmologists detected, in addition to eye problems, other medical problems in about 8% of all patients examined. These were referred to other physicians.

In White House ceremonies opening the pilot test, President Reagan termed the National Eye Care Project "voluntarism at its finest." Commendations have come from many organizations and individuals concerned with health care for older Americans.

Funds for the project are coming entirely from the private sector. The project is expected to cost more than $3 million to operate during 1986. About half of the money is coming from voluntary donations from ophthalmologists themselves. The remainder is coming from several major gifts from corporations associated with the eye care profession, and from other individual donors.

The project's services will be available to elderly throughout the nation by midsummer 1986. An intensive media campaign to publicize the toll-free number will be conducted as each region opens. Ophthalmologists' spouses have volunteered to aid the information effort at the local level.

The Foundation has made a commitment to operate the project indefinitely, so long as resources and volunteer medical services are available.

The goal of American eye physicians and surgeons is to ensure that every older American receives the professional medical and surgical eye care he or she needs, regardless of ability to pay.

AMA offers a workshop to assist physicians and medical office staff in maximization of office efficiency in practice

To assist physicians and medical office staff in making their practice more cost effective, the American Medical Association offers the workshop, "Managing the Business Side of Medicine."

Covering the practice management skills that every practice should have, this valuable one-day workshop gives sound, practical advice in all business areas of practice including telephone management, proper use of appointment scheduling, personnel, medical collections and more.

The workshop is conducted by professional staff of the AMA's Department of Practice Management. All are experienced educators in medical practice management, and conduct educational programs nationwide for physicians and medical office staff.

Workshops are scheduled in Miami, January 17 and April 3, 1986.

The fee for this one-day workshop includes registration, refreshment breaks and workshop materials. To register or for more information, call the AMA Practice Management Registrar collect at (312) 645-4958; or write to the American Medical Association Department of Practice Management, 535 N. Dearborn Street, Chicago, IL 60610.

ENCORES!

Cost effective or quality care: which shall it be?

The title of the article was "The Role of Echocardiography in Cost-Effective Health Care." This was the latest in a series of reports submitted to my editorial office with the phrase "cost-effective health care." It is evidently fashionable to scrutinize current diagnostic and therapeutic modalities for their "cost effectiveness." Is this recent fad simply a rush to use an eye-catching phrase (such as the sadly

over-used word, parameters), or does it portend an orientation toward new priorities in the management of patients?

I submit that a cost-effective approach may be appropriate for office management or industrial technology, but it is unacceptable when applied to patient care. If the clinician makes his therapeutic decisions on the basis of "the most cost-effective" drug or medical device, is the patient aware that he or she may be receiving second-rate medical care? Informed consent has become a moral and legal necessity. This process of self-determination permits the patient to participate in final choices of treatment. Yet many current recommendations, which include cost effectiveness as a decisive force in decision making, fail to include the patient in ultimate choices.

The current annual budget for health care is $325 billion and we are told this is a financial burden that our republic cannot tolerate. Sociologists and financial planners have suggested that hospital administrators, government agencies, and third party payers work together to ameliorate this crisis. We earnestly hope that the medical profession will be called upon in key consultative roles to assist in any modifications of medical care. The participation of the physician, however, as a consultant to the government is a vastly different relationship than the individual clinician's decision to withhold treatment on the basis of cost. The physician establishes with each patient a moral contract to provide the best possible care that is available based upon his/her current knowledge. This moral contract does not permit unilateral decisions by the practitioner to choose a particular test or drug because it is "almost as good, but cheaper." Assumption of such a judgmental role is in conflict with the very basic philosophy of a distinguished profession. If society determines that there must be rationing of health care, then it is the responsibility of society to establish those laws which will be carried out by all citizens, including members of the medical profession.

Some countries now enforce arbitrary rules based upon age, which limit access to kidney dialysis or admission to intensive care units. We hope that the citizens in these countries are aware of the fact that the individual practitioner has not altered his/her relationship with the patient, but that these are administrative decisions imposed upon an entire society. Only in this way can the trust of patients be maintained so that they will recognize that it is, today as always, the clinician's desire and responsibility to offer the best conceivable medical care that society permits.

The medical profession willingly acknowledges that it will have to review medical practices in terms of the urgent need to economize. Duplication of facilities, the practice of defensive medicine, and unnecessary surgery are indeed indefensible and these errors must be corrected. However, there are ways to economize without jeopardizing the quality of care and it is the physician's responsibility to participate in such studies. At no time, however, should the clinician accept the philosophy that the medical professin may compromise its historic pledge to maintain quality of care of regardless of cost. Fiscally sound medical care need not be inferior care. Indeed, in some instances, the most cost-effective choices also offer the finest quality in medical management. However, cost should be only one of the considerations in medical decision-making and of a lesser priority than excellence.

I hope that the phrase "cost effective" will not appear in medical literature in the months ahead. I prefer titles such as "providing quality care more economically." It is entirely correct and currently appropriate to engage in studies that determine whether a particular drug, test or medical device is more economical but equally as good as the agent or test to which it is compared. We cannot do more than this as individual practitioners. Physicians should refuse to inherit the wind of patient anger when such dismay is more correctly related to governmental decisions or corporate interests.

Alfred Soffer, M.D., F.C.C.P.
Park Ridge, Illinois

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I very much appreciate the assistance and encouragement of Dr. Fredric L. Coe in the preparation of this editorial.

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Regulatory boards are working better than ever

It is ironic that consumer groups and the media now are attacking the medical regulatory system in this nation for being effete and incompetent, since these boards are doing a better job now than they have ever done.

Boards of licensure and discipline date back to 1639 in the Virginia colony, and for more than 300 years they have been almost completely ignored by the public and the media despite their almost universal failure to do what they were chartered to do. In fact, the state boards did just the opposite by often protecting the profession at the expense of patients and the public at large.

It is perhaps similarly ironic that a malpractice crisis exists now when medical practice prolongs and saves more lives than ever before.

In just the past 10 years, many boards have begun to perform their statutory roles more effectively as the arbiters of medical practice in their states. This must be attributed in great part to public interest in malpractice, the cost of care and consumer issues in general.

I must take some credit for bringing media attention to this matter by having written an article that was recently published in the *New England Journal of Medicine* (March 21, 1985). The Journal's editor, Arnold Relman, M.D., wrote an editorial comment about my article in the same issue, and it is important to note that, aside from these references, the medical and lay literature have been almost devoid of material relating to state boards and the regulatory system.

The Public Citizen Health Research Group report on medical malpractice and the need for disciplinary reform instead of tort reform reiterates data reported by me in the *New England Journal* for the year 1982 and updated by the Federation of State Medical Boards for the years 1983 and 1984.

It is quite obvious from the data that medical boards are not disciplining many physicians, and even the most efficient states, like Florida and Utah, are doing only a marginal job of removing incompetent doctors. The best states discipline just fewer than one doctor per 100 per year, and many states do not discipline any doctors at all.

The authors' editorial comments strongly affirm their opinion that the malpractice crisis has been created by bad doctors and a failure of the regulatory process. They want to halt attempts at legislative tort reform and malpractice relief, which they view as anti-consumerist and wrong, and instead make several suggestions to improve the disciplinary process.

They contend that the regulatory system is not working and suggest improvements, and they believe that bad doctors have created the malpractice crisis.

Although medical boards have improved considerably in the past decade, there is still a very long way to go. In a sense, the disciplinary system in most states is in its infancy. Although the Federation of State Medical Boards was chartered in 1912, it only recently began to compile and share disciplinary reports. The federation is a slave to its member states, which fund it through their purchase of the FLEX test for licensure applicants. Until recently the complacency of member boards engendered an inefficient parent organization.

The notion of medical regulation is unknown in most other nations of the world, including many nations in western Europe, and despite our deficiencies, we still do the best job of any other nation.

The report suggests increasing licensing fees to $500 per year per physician to make funds available to disciplinary boards; passing strong legislation to expand the size and strength of disciplinary boards; requiring insurers to experience rate doctors; requiring attorneys and the courts to file reports on doctors who have lost malpractice suits; making all other data, such as material from PRO files, available to disciplinary boards; periodically recertifying.

To comment: there is no question that more money will make better regulatory boards, and most states' medical license renewal fees are too low. The Florida board just voted to increase our fee from $50 to $100 every two years. Along with regulatory reform in 1979, there was an increase in funds available for use by the medical board from $650,000 in 1979 to $2.2 million in 1984.

In Florida, almost every detail of board activity, from the cost of renewal fees to the number of telephones and secretaries in the cramped medical office in Tallahassee, is controlled by the Legislature. This causes every request for change to become a laborious and political process. The Secretary of DPR needs more freedom to allocate funds from the licensure trust fund for specific board needs and requests.

Salaries paid to investigators, prosecuting attorneys and board personnel are often too low to attract and retain the high quality personnel needed to do the job. When a physician is charged by the board with an administrative complaint, you can be certain that he will hire the best administrator or criminal attorney his money can buy.

Federal peer review orgainzation regulations provide confidentiality for physicians whose hospital records are examined by PRO reviewers to compile data. The reviews do at times show evidence of gross overutilization of hospital resources and possible malpractice, and these findings should be made available to state regulatory boards.

The Florida Board of Medical Examiners has been trying for more than three years to get new legislation that would improve our ability to screen out possible fraudulent and incompetent graduates of certain foreign medical schools who seek licensure in Florida. Yet the Legislature has viewed this as a political problem and refused to help. What better way is there to create a future malpractice problem than to offer a deaf ear to a medical board that seeks ways to keep possibly incompetent and fraudulent physicians from obtaining a medical license in this state?

The Health Research Group also alleges that bad doctors and a failed disciplinary system have created the malpractice crisis.

In a presentation I made in October 1984 to the Medical Malpractice Task Force of the South Florida Health Action Coalition in Tampa, it was my contention then, as now, that doctors who are sued for malpractice are generally competent and sometimes

even outstanding physicians who work in areas like obstetrics, and neurosurgery. These fields are fraught with the potential for bad results. I once read that the chairmen of neurosurgery of all seven medical schools in New York City had pending malpractice suits against them.

I do not believe there is an association between a failed disciplinary system and rising rates of professional liability insurance and the size of jury awards.

Many incompetent physicians practice in rural areas, prisons, state mental hospitals and among the urban poor, and they are never sued for malpractice despite the great personal and financial harm they inflict upon their patients and society at large. Neither are these physicians generally detected by the disciplinary system, because a physician cannot be charged and disciplined without first being discovered and investigated.

Despite differences with certain aspects of their report, I welcome the Public Citizen Health Research Group report as a necessary contribution to a small but growing literature on this subject. If we think and write about incompetent physicians, malpractice and the regulatory process, then we will arrive at ways to make improvements that eventually will benefit patients and all citizens.

Although many consumer groups want to see more public members on medical boards, I believe the physician members have been the most diligent in trying to make certain that only qualified and competent physicians are allowed to receive and retain a medical license in Florida.

The disciplinary process in this state utilizes lawyers as hearing officers, and in almost every case physician medical board members want stricter discipline and more severe penalties than the hearing officer recommends. These discrepancies force some board decisions to be reversed by the appeals courts in favor of the lighter penalties suggested by the hearing officer.

A serious shortcoming of the system is the failure to investigate and discipline physicians for medical incompetence, because they are not complained about by patients or other physicians. Medical boards tend to discipline felons or doctors who over-prescribe controlled drugs.

Complaints about incompetence will only increase when physicians decide to "snitch" against colleagues who they believe have violated the law and harmed patients, and when patients become more sophisticated and less fearful about filing a complaint against a member of the medical profession.

Richard J. Feinstein, M.D.
Miami

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Thoughts on the Medical Malpractice Reform Act of 1985

Last night I attended the Sacred Heart Hospital "Medical Malpractice Reform Act of 1985" Seminar.

As the late afternoon golden autumn sun fell slowly across the pure blue sky, punctuated with soft cotton-ball clouds, my mind, instead of enjoying the beauty of a perfect day, was troubled. The warm sun, crisp air and clear autumn sounds could not dispel the dread, bitterness and fear of the meeting. Bitterness of exchanging a relaxing evening at home for a boring and unpleasant meeting, dread of what I may hear and fear of how my practice life might be changed. A few days ago I told one of my partners I was not going because no new information regarding avoiding malpractice suits could possibly be given. There is no new advice beyond practicing good medicine, talking kindly to patients, keeping honest, accurate medical records and maintaining professional liability insurance. Nevertheless I went. I sought my wife's advice, shared the title with her and told her I really did not want to go. She thought I should go, it sounded important. So, out of duty, fear of missing something important and plain conformity (because most others would go) I went.

I was surprised when I arrived to see only a few people present. Ultimately I estimated approximately a third of the staff came. The table containing the sign-in sheets stood in the foyer. This provoked my first burst of sadness. No one trusts us anymore. Our word of honor indicating attendance is not enough. I see a "steelcase" file cabinet in a neat, decorously (if not luxuriously) decorated administration office filled with 1/3 cut manila file folders with neatly typed labels: Westmark, Edward R., and similarly for each staff member. This file is cold, sterile and dead. It does not possess honesty, honor, integrity or any other human quality. It contains a green and white ruled computer paper depicting us as a set of attendance numbers. Pure arithmetic. Mathematics is beautiful but it is not us and we do not want to be numbers. Sad! And how ironic. We, the alleged perpetrators of "dehumanized medical care" are ourselves being dehumanized to performance and attendance numbers, and we abhor it. Is it true we are no longer trustworthy and must be monitored so closely? Our patients say we cannot be trusted. Our government says we cannot. Our jurisprudence systems says we cannot. Our hospitals say we cannot. If it is true a sad era is upon us. If it is not true, why do we accept the allegation so passively?

I walked into the auditorium. It was filled with rows of tables stretching from wall to wall. The first time I had seen it so. In the rear a buffet dinner gave

off the tantalizing scent of fried chicken. Appetizing vegetables, iced tea and soft drinks complemented the chicken. Surely, I thought, this is the historic last meal of a "condemned criminal." I had already eaten so I chatted with colleagues. Their talk was the joking, nervous "gallows humor" that precedes an event of great import in our lives. I saw it before each big test in medical school. I thoughtfully studied their faces. They were lined and drawn with dilated pupils. Fear showed. Their demeanor was one of listless resignation. "I do not want to be here. Let's have the bad news and get it over with." The ubiquitous "Medicine is no longer fun to practice" and "If I can just make it another 5, 7 or 10 years and get my retirement plan funded I am quitting" resounded. Sad! Frustrated, unhappy, besieged, angry, hard working, intelligent men and women feeling helpless and betrayed. A life of service that in earlier years promised satisfaction, now soured, ruined and drudgery. Worsening, all the while.

As I sat waiting and thinking I was introduced to the speaker. A pleasant "yuppie" appearing young man, with well cut dark grey pin-striped suit, white shirt and decorously patterned red tie. Social smile and outgoing manner. Neat and intelligent. At his formal program introduction I learned he was an attorney for the Florida Hospital Association. I jolted at this news. Why should the medical staff be listening to the Medical Malpractice Reform Act explained by the hospital's attorney? Should we not have it explained to us by a medical staff attorney? No matter. I am sure we are being given the perception that we are one of the cooks when in truth we are part of the ingredients.

We each received a handout containing a "detailed summary of HB 1352." I thought about the title of the bill. "The Medical Malpractice Reform Act of 1985." The dictionary defined reform as: 1. the improvement or amendment of what is wrong, corrupt, etc. 2. amendment of conduct. 3. to restore to a former and better state; improve by alteration, substitution, abolition, etc. 4. to cause a person to abandon wrong and evil ways of life or conduct. 5. to put an end to abuses, disorders, etc.

Since we are the only people who practice medicine, we are the only ones who can commit medical malpractice. The bill, therefore, must be addressing us (physicians). How did we fall so far, so fast to deserve the adjectives wrong, corrupt, evil, abusive and disorderly. My head was spinning. Once we were respected and loved. Now the legislature, representing all our patients, is compelled to reform us. It is true, we are evil, do wrong and abuse, but no more than our patients. We are human. I watch my colleagues at work and I do not see evil, abuse and wrongdoing. I see intensely interested, caring physicians working as hard as humanly possible to cure their patients. The problem is we are not allowed any normal, human errors. If we become mortal and make any mistakes we are labelled "in need of reform." We must achieve perfection and that has only been done by one person, Jesus Christ, in all of history. Our predicament is impossible. We are caught in a great tidal wave of hostile social change seeking the impossible.

Each week I receive so many directives, announcement, rulings, newsletters and reports from the hospital, AMA, FMA, Federal Government, Escambia County Medical Association and State government that I cannot keep up with them nor long remember them. And this does not count keeping up with the legitimate scientific body of medical information that becomes obsolete every 5 years. Then I am admonished by all to "be involved." My community, my church and my family need me. I feel I am "involved," over-involved, in a hostile world that no longer likes or appreciates physicians, indeed, now finds us to be a scourge and the cause of many of its troubles.

My reverie ended as the explanation of 36 of 46 sections in the bill began. Immediately with the first section, questions were asked. The young attorney answered them from the hospital's viewpoint. When queried about the doctors' standpoint he had no answer. He clearly, affably and politely wove his way through sections dealing with our staff memberships, clinical privileges, medical staff discipline, Department of Professional Regulation discipline, cooperation and insurance carriers, Hospital Quality Assurance, Hospital Risk Management, punitive damages, pre-suit screening, arbitration, attorneys' fees, pretrial settlement conferences, joint and several liability, unnecessary diagnostic testing, risk management education and peer review records. Each nicely explaining how the hospital will approach them. I was and still am angry, frustrated and resigned to an unhappy decade of medical practice. I feel already convicted without benefit of trial and out on probation. All will be fine if I follow everybody's rules and am careful not to be human and ever make a mistake. If I do, a dozen reports will immediately emanate to various committees and my career may silently and softly end with dismissal from the medical staff and loss of license. All because I tried hard to abide by an impossible and increasing number of rules that tell me I am not to be trusted as an honest and competent physician. The psalmist captures my feelings in Psalm 25 Verses 17 and 18: " The troubles of my heart have multiplied; free me from my anguish. Look upon my affliction and my distress and take away all my sins."

All left the meeting despondent. What can we do? Nothing. Hurry home, catch the second half of Monday night football and wait for the inexorable pendulum swing. Paul in 2 Corinthians 4:8 and 9

knew and expressed our feelings best: "We are hard pressed on every side, but not crushed; perplexed but not in despair; persecuted but not abandoned; struck down, but not destroyed.

Edward R. Westmark, M.D.
Pensacola

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SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"The altered script scam"

Prescribers who short-cut proper prescription writing practice, especially those who use arabic-numerals for dose amounts (not reinforced by a written number), are easy marks for professional patients. By simply matching the ink color of the prescribers pen or ball-point, a prescription for 10 can become a prescription for 40, 5 can become 25. A prudent prescription becomes excessive, and proportionally more profitable to the professional patient.

Caution • Prescribers are cautioned to always follow good prescription writing practice; use ink or indelible pencil; write out actual amount of medication prescribed in addition to Arabic or Roman numerals and never leave prescription pads unattended.

CORRECTION

The following chart should have appeared on page 947 of the November issue of *The Journal* (Vol. 72, No. 11) instead of the chart that was shown.

Table 1. — Prenatal Care by Age and Number of Visits

	Age		
	≤ 19 years	≥ 20 years	Total
No. of Visits	n(%)	n(%)	n(%)
0	5(10%)	5(10%)	10(10%)
1-4	9(19%)	5(10%)	14(14%)
5-8	10(21%)	19(36%)	29(29%)
≥ 9	24(50%)	23(44%)	47(47%)
Total	48*(100%)	52**(100%)	100(100%)

* 2 missing responses
** 1 missing response

BOOK REVIEWS

Book Review Editor — F. Norman Vickers, M.D.

Beyond the next mountain: an autobiography by Robert Crawford Woodward, December 9, 1867 — August 31, 1949

Privately printed by Jewell W. Alderman and Mae Knight Clark, 122 pages, Price $14.95. Banyan Books.

There are those among us for whom adversity serves as a springboard to greatness. Such a one was Robert Crawford Woodward, M.D. In this autobiography, published several months ago, the central theme is the ingenuity, vigor and persistence with which Woodard met seemingly insurmountable problems and overcame them. To put his philosophy in his own words: "But in all this, my resolution to succeed in life was so firm, so intense, that I never for a moment gave thought to the possibility of failure in anything that might be undertaken."

Woodard was born to a South Georgia family shortly after the Civil War. His family, once wealthy plantation owners, were barely able to feed and clothe themselves in those stringent times. By dint of hard work, first on the farm and later as an accountant, he obtained a public school and business school education. He served as a teacher and later superintendent of schools in Adel, Georgia. His thirst for knowledge still not satisfied, he determined to go to medical school and become a physician. With financial help from friends and the State of Georgia, and with steadfast support from his wife and family, he attended the full course of study at the Medical Department of the University of Georgia in Augusta, graduating with honors.

He set up practice in Cecil, Georgia, but after six months moved to Adel, Georgia, where he practiced medicine and surgery and with another physician built the first hospital in that area. A community-minded man he continued to work with the school system and took a keen interest in local politics. Indeed, he became adept at representing his area in the state legislature and spearheaded the drives that esatablished three south Georgia counties: Cook, Lanier and Lamar.

Hard times fell on South Georgia when the boll weevil came to destroy the "money crop," Sea Island cotton. Again Woodard was dogged by adversity. Looking for an area where he could better provide for his family, he visited his nephews in Miami. Things were much more promising here so he moved his family down and opened a practice here in late 1921. There followed the heady days of the real estate boom, the devastating hurricane of 1926 and again the economic hard times of the great depression.

Woodard took an active part in the medical community and was elected president of the Dade County Medical Society in 1927. He also took a keen interest in civic affairs and was represented by the "movers and shakers" of the community. In 1931, the Miami City Commission appointed him superintendent of the James M. Jackson Memorial Hospital. This appointment initiated one of the most challenging periods of Woodard's life. At this time money was scarce and yet there was great need for the modernization of the hospital facilities and the provision of more beds. This autobiography provides much insight into the problems of that period, how they were addressed and the names of those who, with the constant goading of Woodard, brought the hospital to the first rank of the nation's hospitals by the beginning of World War II.

A heart attack in 1940 forced Dr. Woodard to resign his position as superintendent. After a convalescent period, he opened his office on Northwest Twelfth Avenue where he practiced general medicine until his death from heart disease in 1949. Always eager for knowledge he continued to take postgraduate courses and attend conferences up until his final illness.

Georgia history buffs will find his small volume a source of material on daily life in South Georgia and Georgia politics during the first two decades of this century. Dade County historians will find it useful in the study of the depression days of South Florida, especially as they affected the Jackson Memorial Hospital during those stringent times. All readers will find his life an inspiration and a stimulus to redouble their efforts when going gets rough.

William M. Straight, M.D.
Coral Gables

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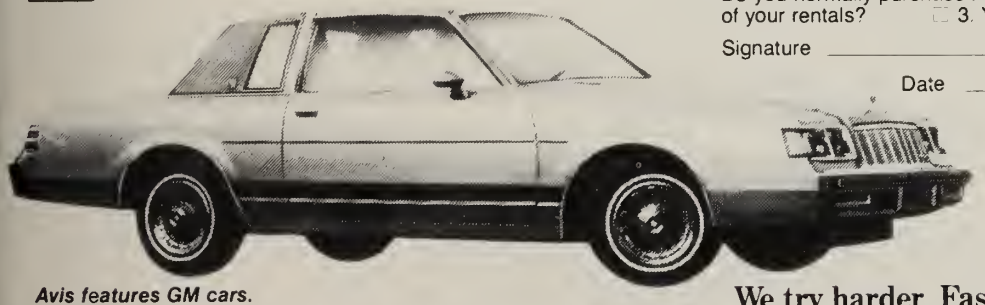

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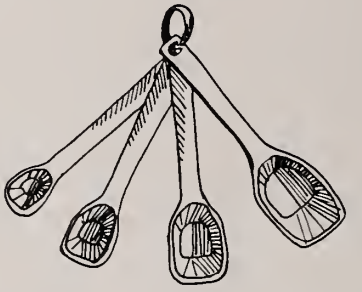

KEY LIME PIE

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4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice; mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving

*You can make the meringue with only 4 egg whites from the eggs you've used

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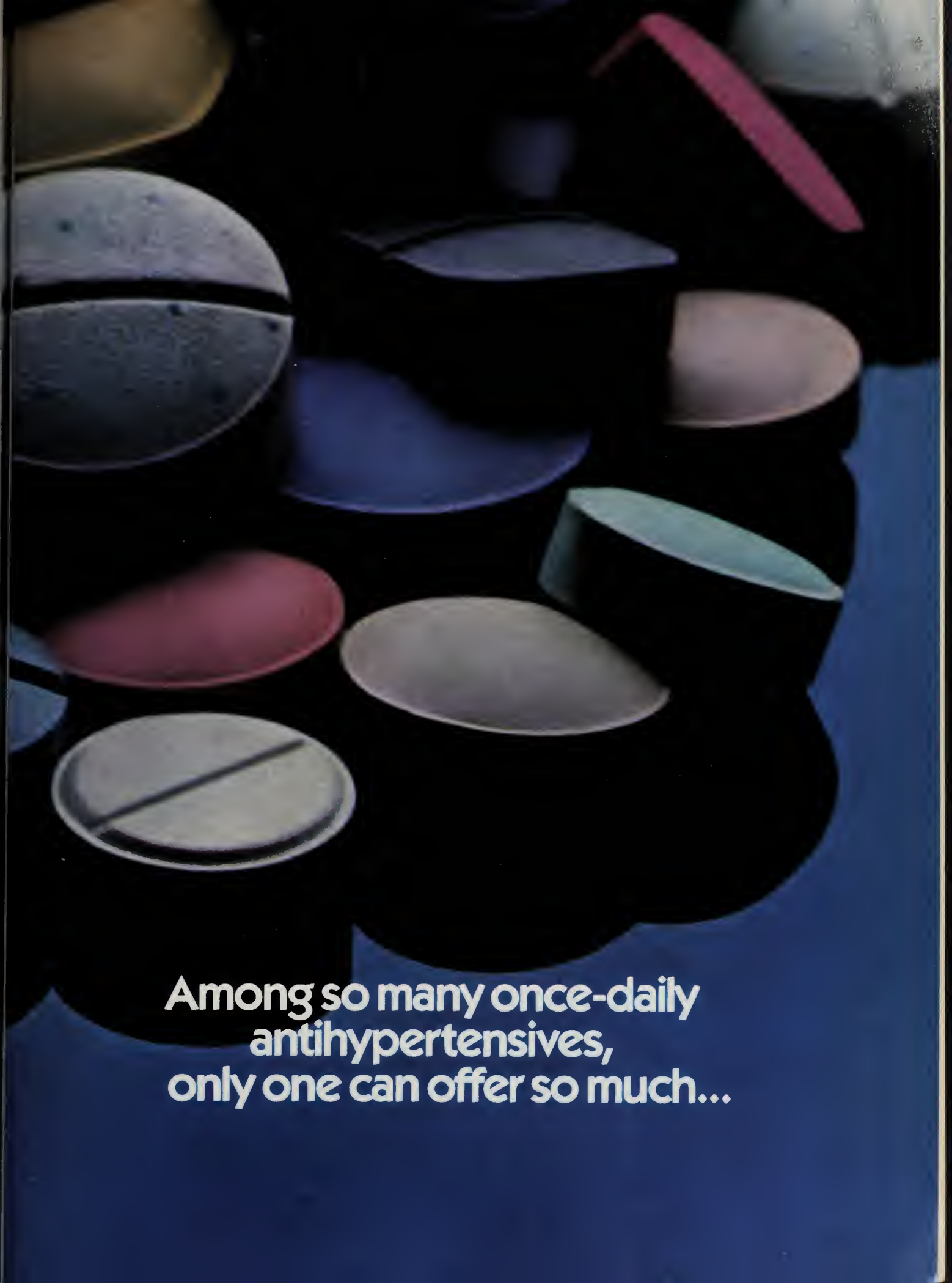
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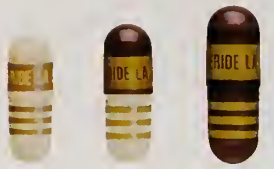

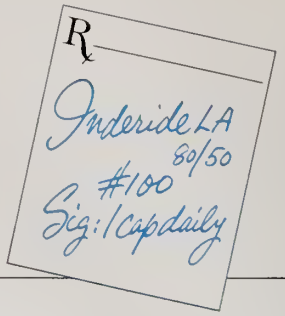

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Propranolol hydrochloride (INDERAL® LA)	80 mg
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No. 459—Each INDERIDE® LA 160/50 Capsule contains	
Propranolol hydrochloride (INDERAL® LA)	160 mg
Hydrochlorothiazide	50 mg

INDERIDE LA is indicated in the management of hypertension.

This fixed-combination drug is not indicated for initial therapy of hypertension. If the fixed combination represents the dose titrated to the individual patient's needs, therapy with the fixed combination may be more convenient than with the separate components.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL®):

Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide:

Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL®):

CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patients should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide:

Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL®):

GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide:

GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL®):

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis); fever, respiratory distress (including pneumonitis), anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

5112/985

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Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

The first male spouse in the Dade County Auxiliary

I never intended to be a pioneer, and I never expected to be the first male member of the Dade County Medical Association Auxiliary, but here I am with this singular honor and privilege.

Nancy, my wife, has been a physician for 24 years. I have been married to Nancy for 26 years, and we have accumulated five children. Is it any different for a male spouse than it is for a female spouse? That is a good question. The answer is probably no.

We suffered through medical school together as you did, and then, in turn, internship and two residencies; pediatrics and psychiatry. Her on-call nights traumatized all of us the same way yours did, and our telephone still causes the same separation that yours does.

Maybe there were some things that were different. When Nancy stayed at the hospital overnight, I would march the children down and we would all sleep there overnight together and wait to take her home again. When she became Chief of Psychiatry at Miami Children's Hospital, I became the administrator of the division so that the children and I could see her frequently.

I took a lot of love and caring, and I think if I were to really answer the question and how it feels to be the male spouse of a physician, I would have to say that the real question is how did a woman become a physician, rear five children, and stay married to me for 26 years? Possibly becoming a therapist myself so that we could continue to work together made the difference. Her profession as a child psychiatrist has had a profound influence on the raising of our children.

All we really did over the years was to adjust to each other's needs both personally and professionally. Maybe that is how we were successful at it. But did you all not do the same thing?

Unlike the previous new members, my participation is, I am sure, going to be much more noticed than have new members in the past. I will be getting used to discussions involving "our husbands," remembering that "ladies" does include me. It is impressive for all of us to realize that 30 percent of the physicians in Florida today are women. That means a large number of male spouses are eligible for membership in the medical auxiliary.

I only hope that my pioneering days will quickly be over as far as the medical auxiliary is concerned. Come on fellow male spouses and join me. Honestly, it is not really lonely here at the top, and I think that all the members together can really help to make the Auxiliary a fantastically dynamic organization.

In any case I am thrilled to be one of the first males to be a member of the Dade County Medical Association Auxiliary, and I hope that my participation will be up to the standards set by my fellow members during the 22 years that I have waited for the privilege.

Melvin C. Greenfield, Ph.D.
Miami

An Invitation from the Florida Medical Association

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Meetings

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JANUARY

Florida Thoracic Society 8th Annual Pulmonary Winter Course, Jan. 9-12, Contemporary Hotel, Lake Buena Vista. For more information: Milton Braunstein, M.D., 12901 N. 30th Street, Tampa 33612, (305) 463-3131.

Thirty-first Annual Cardiovascular Seminar, Jan. 10-11, Sheraton Sand Key Resort, Clearwater Beach. Contact: Anita Godsey, P.O. Box 7188, St. Petersburg, FL 33734, (813) 526-6000.

Omni-Specialty Medical Update, Jan. 12-14, Naples Bath and Tennis Club, Naples. Contact: James Marion, M.D.

One-Day Diabetes Management Course, Jan. 13, University of South Florida, Tampa. Contact: Anthony Morrison, (813) 974-4360.

The Economic Impact: Drug Abuse in the Work Force, Jan. 15-17, James L. Knight International Club, Miami. Contact: Conference Center, 400 S.E. 2nd Avenue, Miami, FL 33131, (305) 372-0140.

Eighteenth Annual Postgraduate Seminar in Pediatric and Adult Urology, Jan. 15-18, Sheraton Bal Habor, Miami Beach. Contact: Victor A. Poktano, M.D., Dept. of Urology, 6614 Miami Lakes Drive East, Miami Lakes, FL 32014, (305) 687-1367.

Cardiology Tutorials in the Wilderness, Jan. 18-25, Canoe Trip, Everglades. Contact: Peter E. Pool, M.D., UCSD School of Medicine, La Jolla, CA 92093, (619) 452-3940.

Eleventh Annual Review and Recent Practical Advantages in Pathology, Jan. 19-24, Hyatt Hotel, Miami. Contact: A. Morales, M.D., P.O. Box 016960, Miami, FL 33101, (305) 549-6437.

Symposium on Cancer Biology and Therapeutics, Jan. 20-22, Curtis Hixon Convention Center, Tampa. Contact: J. G. Cory, Ph.D., Medical Center, Box 46, 12901 N. 30th Street, Tampa, FL 33612.

MedTech '86, Jan. 20-22, Curtis Hixon Convention Center, Tampa. Contact: International Conference Management, c/o The Madison, 15851 Dallas Parkway, Suite 1155, Dallas, TX 75248, (214) 458-7011.

Annual Symposium on Cancer Biology and Therapeutics, Jan. 20-22, USF College of Medicine, Tampa. Contact: Joseph Cory, Ph.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4296.

Practical Imaging of the Head and Spine, Jan. 23-26, Palace Hotel, Lake Buena Vista. For More info: Lawrence Muroff, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813)873-2090.

Digital Radiography, Jan. 23-26, Palace Hotel, Lake Buena Vista. For more info: Lawrence Muroff, (813) 873-2090.

AIDS: Epidemic of the 80's, Jan. 24, Hyatt Regency, Miami. Contact: Sharron Shelton, 33 Millwood, Mill Valley, CA 94941, (415) 361-5600.

MRI/CT Ultrasound Correlations, Jan. 26-30, Sheraton Bal Harbour, Bal Harbour. Contact: Lucy R. Kelley, P.O. Box 343762, Coral Gables, 33134.

A Practical Approach to Solutions and Problems in Burn Care, Jan. 30-Feb 1, Clearwater Beach. Contact: C. Wayne Cruse, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4296.

Vascular and Pulmonary Diseases: Diagnosis and Management, Jan. 31-Feb. 2, Don Cesar Hotel, St. Petersburg. Contact: Stephen E. Mattingly, (303) 798-9682.

FEBRUARY

Ultrasound Integrated into Modern Ob-Gyn, Miami Beach. Contact: William A. Little, M.D., P.O. Box 016960, Miami, FL 33101, (305) 549-6944.

Internal Medicine — Selected Aspects, Feb. 1-8, Telluride, Colorado. Contact: Gloria Allington, P.O. Box 016960, Miami, FL 33101, (305) 547-6716.

Twelfth Annual Bail Conference in Anesthesiology, Vail, Colorado. Contact: Brian Craythorne, M.D., P.O. Box 016960, Miami, FL 33101, (305) 547-6411.

Controversies in Carcinoma of the Breast, Feb. 1-8, Snowmass, Colorado. Contact: Martin Silbiger, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-2538.

Eighteenth Miami Winter Symposium — Advances in Gene Technology, Feb. 3-7, Hyatt Regency Hotel, Miami. Contact: William J. Whelan, P.O. Box 016960, Miami, FL 33101, (305) 547-6265.

Ninth Annual Advanced Ultrasound Seminar, Feb. 5-8, Palace Hotel, Lake Buena Vista. Contact: Lennard Greenbaum, M.D., Orlando Regional Medical Center, Orlando 32806-2093, (305) 841-5144.

Hair Replacement Surgery for the Beginner, Feb. 5-9, Miami Airport Hilton, Miami. Contact: Sorrel S. Risnik, M.D., 9065 S.W. 87 Ave., Suite 109, Miami, FL 33176, (305) 279-6060.

Twelfth Annual Symposium on Cosmetic Surgery, Feb. 6-8, Hyatt Regency, Miami. Contact: Thelma MacGregor, 1400 N.W. 12th Avenue, Miami 33136.

Twenty-third Annual Neuro-ophthalmology Course, Feb. 6-8, Sonesta Beach Hotel, Key Biscayne. Contact: Hilary Hose, 6125 S.W. 31 Street, Miami, FL 33155, (305) 667-7060.

ECG Workshop, Feb. 7, Hilton Hotel, Jacksonville. Contact: Merrill A. Anderson, M.D., 4057 Carmichael Avenue, Jacksonville 32207, (904) 398-5667.

Flexible Sigmoidoscopy Workshop, Feb. 7, Hilton Hotel, Jacksonville. Contact: Merrill A. Anderson, 4057 Carmichael Avenue, #229, Jacksonville 32207, (904) 398-5667.

Fortieth Regional Family Practice Weekend, Feb. 7-9, Hilton Hotel, Jacksonville. Contact: Merrill A. Anderson, FAFP, 4057 Carmichael Ave., #229, Jacksonville 32207, (904) 398-5667.

Urologic and Potential Problems in Pregnancy, Feb. 10-12, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Pulmonary, Allergy and Infectious Diseases, Feb. 10-14, Palace Hotel, Lake Buena Vista. Contact: Udaya Prakash, M.D., 200 1st Street, S.W., Rochester, MN 55905, (507) 284-2511.

Communicating with Patients, Feb. 13-14, Hyatt Regency, Tampa. Contact David H. Smith, Ph.D., USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 974-3294.

Economics of Diagnostic Imaging, Feb. 13-14, Palace Hotel, Lake Buena Vista. Contact: Lawrence Muroff, (813) 873-2090.

Pediatrics for the Practitioner, Feb. 14, USF College of Medicine, Tampa. Contact: Herbert Pomerance, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4214.

Seventh Annual International Gastroenterology Conference, Feb. 16-20, Hilton Hotel, Lake Buena Vista. Contact: Sidhi Tewari, M.D., (305) 841-5144.

Strategies in Oncology/Hematology for the Family Practitioner, Feb. 17-22, Saddlebrook Resort, Tampa. For more information: Marge Adey, 42nd Dewey Avenue, Omaha, Neb. 68105, (402) 559-4152.

Conference on the Beach, Feb. 17-22, Daytona Hilton, Daytona Beach. Contact: Tariq Siddiqui, M.D., P.O. Box 1990, Daytona Beach, FL 32015, (904) 254-4051.

Sarasota Vitreoretinal Update Course, Feb. 20-22, Colony Beach and Tennis Resort, Longboat Key. Contact: James Kingham, M.D., (813) 921-5335.

Practical Aspects of Newer Cardiovascular and Renal Drugs, Feb. 20-23, Orlando. Contact: University of Miami, Division of CME D23-3, P.O. Box 016960, Miami, 33101, (305) 547-6716.

Pediatric Dermatology Seminar, Feb. 20-23, Eden Roc Hotel, Miami Beach. Contact: Guenter Kahn, 16800 N.W. 2nd Avenue #401, N. Miami Beach, FL 33169, (305) 652-8600.

Thirteenth Annual Symposium in Pediatric Nephrology, Feb. 23-27, Miami. Contact: University of Miami, P.O. Box 016960, Miami 33101, (305) 549-6726.

Update on Surgery and Management of Colorectal Diseases, Feb. 24-26, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Neurology Update, Feb. 25-March 2, Sheraton Bal Harbour, Bal Harbour. Contact: University of Miami, Division of CME D23-3, P.O. Box 016960, Miami 33101, (305) 547-6716.

Eighteenth Teaching Conference in Clinical Cardiolgy, Feb. 26-March 1, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., D-41, P.O. Box 016960, Miami 33101, (305)547-6491.

Health Care of the Elderly, Feb. 27-March 1, USF College of Medicine, Tampa. Contact: Eric Pfeiffer, M.D., 12901 N. 30th Street, Tampa 33612, (813) 974-4355.

Current Concepts in Surgery of the Gastrointestinal Tract, Feb. 27-March 1, Diplomat Hotel, Hollywood. Contact: University of Rochester, 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Surgical Anatomy of the Eyelids, Orbit and Lacrimal Apparatus, Feb. 27-March 1, Lincoln Hotel and USF College of Medicine, Tampa. For more info: Jay J. Older, M.D., 12901 N. 30th Street, Tampa 33612, (813) 974-3170.

MARCH

Difficult Questions for Pulmonary Medicine, March 1, The Rusty Pelican, Tampa. Contact: David A. Solomon, M.D., 13000 N. 30th Street (111C), Tampa 33612, (813) 972-2000.

Internal Medicine 1986, March 2-7, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bodes, M.D., P.O. Box 016760, Miami 33101, (305) 547-6063.

Internal Medicine Update, March 2-8, Palace Hotel, Lake Buena Vista. Contact: Barry Sieger, M.D., (305) 841-5144.

Epidemiology and Prevention of Cardiovascular Disease, March 3-5, Good Samaritan Hospital, West Palm Beach. For more info: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Neuroradiology: New Horizons and Current Concepts, March 3-6, Sheraton Bal Harbour, Bal Harbour. Contact: Robert M. Quercer, M.D., P.O. Box 016960, Miami 33101, (305) 547-6716.

Neuroradiology: New Horizons and Current Concepts of Classic Issues, March 3-7, Sheraton Bal Harbour, Miami. Contact: Joyce E. Freeman, P.O. Box 016960, Miami, FL 33101 (305) 549-6894.

Florida Society of Ophthalmology Annual Meeting, March 6-8, Palace Hotel, Lake Buena Vista. For more info: Florida Society of Ophthalmology, 1133 W. Morse Boulevard, #201, Winter Park 32789, (305) 647-8839.

Ophthalmology Talks, March 7-8, Palace Hotel, Lake Buena Vista. Contact: Avery Weiss, M.D., (813) 974-3170.

Twenty-First Annual Meeting of the American Society of Contemporary Medicine and Surgery, March 9-13, Diplomat Hotel, Hollywood. Contact: John G. Bellows, M.D., 211 E. Chicago Ave., Sute 1044, Chicago, IL 60611, (312) 787-3335.

Problems in Rheumatology, March 12-15, Don CeSar Beach Resort Hotel, St. Petersburg Beach. Contact: Bernard Germain, M.D., USF College of Medicine, Box 19, Tampa 33612.

Breast Disease Update III, March 12-16, Hilton Hotel, Lake Buena Vista. Contact: Noel Zusmer, M.D., 4300 Alton Road, Miami Beach, FL 33140, (305) 674-2418.

Pediatric Urology; for the Urologist, March 14-16, Doral Beach Hotel, Miami Beach. For more info: American Medical International, 6614 Miami Lakes Dr. East, Miami Lakes 33014, (305) 687-1367.

Pediatric Intensive Care, March 17-19, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Eighth Annual Family Practice Review, March 17-21, Adam's Mark Caribbean Gulf Resort, Clearwater Beach. Contact: Charles Aucremann, M.D., 701 6th Street South, St. Petersburg, FL 33701, (813) 893-6156.

Infectious Disease and Antibiotic Therapy, March 18-22, Palace Hotel, Lake Buena Vista. Contact: Barry Sieger, M.D., (305) 841-5144.

Contemporary Hepatology, March 20, USF, Tampa. Call: William Boyd, M.D., (813) 972-2000.

Seventeenth Annual Topics in Internal Medicine, March 20-22, Gainesville Hotel, Gainesville. Contact: A. Jay Block, M.D., JHMHC J-233, Gainesville 32610, (904) 392-3143.

Issues in Perinatal Care 1986, March 21-22, Halifax Hospital, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Boulevard, Daytona Beach. (904) 252-4701.

Vascular and Pulmonary Diseases: Diagnosis and Managment, March 21-23, Bahia Mar Hotel, Ft. Lauderdale. Call: Stephen E. Mattingly, (303) 798-9682.

Advances in Diagnostic Imaging, March 22-30, Switzerlan, St. Moritz. Contact: Lawrence Muroff, M.D., (813) 974-7267.

1986 Update on Diseases and Imaging, March 31-April 2, Walt Disney World Village Hotel, Lake Buena Vista. Contact: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813)974-2538.

APRIL

Critical Care Medicine, April 1-5, Hotel Royal Plaza, Lake Buena Vista. Call: Alan Varraux, (305) 841-5144.

Radiology of Hepatobiliary and Pancreatic Disease: Imaging and Intervention, April 1-5, Miami Hyatt Regency, Miami. Contact: Jill Nolden, Division of Diagnostic Radiology, P.O. Box 016960, Miami, 33101, (305) 549-6894.

Fourth Annual Interventional Radiology Seminar, April 2-5, Palace Hotel, Lake Buena Vista. Contact: Martin Selbiger, M.D., (813) 974-2538.

Regional Cancer Conference, April 8-11, Lake Buena Vista, Lake Buena Vista. Call: Clarence Brown, M.D., (305) 841-5144.

Forty-First Regional Family Practice Weekend, April 11-13, Lincoln Hotel, Tampa. Contact: Robert L. Dawson, M.D., 4057 Carmichael Ave., #229, Jacksonville 32207, (904) 398-5667.

1986 Radiation Therapy Seminar, April 17-19, University Centre Hotel, Gainesville. Contact: Division of Radiation Therapy, JHMHC J-385, Gainesville, 32610.

Clinical Virology Seminars, April 21-23, Holiday Inn Surfside, Clearwater. Contact: Steven Specter, Ph.D., USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 974-2178.

Physiology of Fitness, April 22-26, Sonesta Village Hotel, Orlando. For more info: Alan Varraux, M.D., (305) 841-5144.

MAY

Five-Day Diabetes Management Course, May 12-16, USF College of Medicine, Tampa. Call: Anthony Morrison, (813) 974-4360.

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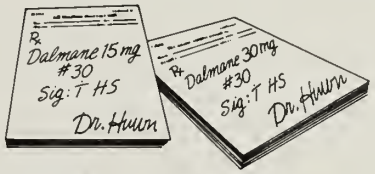

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